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SUPPLEMENT

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A TRANSFORMATION THROUGH PSYCHOTHERAPY AND SPECIAL EDUCATION

BY LUMA LOUIS KOLBURNE, M. A.

Many children in our schools present educational and behavior problems indicative of various types and degrees of maladjustment. Such children often cannot cope with the regular school routine and are sometimes thought to be mentally deficient because of their low scores on intelligence and achievement tests.

Those responsible for the education, training, guidance and care of such children are often perplexed by difficulties and problems which, at times, appear to be incapable of solution. When children with serious maladjustment problems have been so well readjusted that they can successfully cope with life in their communities, the means, methods and procedures employed in their rehabilitation may be of practical value to others with similar responsibilities.

Perhaps the best method of gaining an insight into the complex problems involved in the correction of maladjustment in children is to study the available concrete data concerning individual cases. This approach enables one to organize the various constituent aspects of the problem into a picture of the total situation and also reveals the pattern of readjustment, so that an evaluation may be made of the methods and procedures utilized.

The Case of B.

The Problem. B. was admitted to a small, special school in July 1940.* He had just turned 13 and appeared to be hopelessly retarded, socially maladjusted and emotionally unstable. Scholastically, he could not perform second grade work, and he exhibited a pattern of complete dependence. What, if anything, could be done to help this boy?

Physician's Report

History. "He began kindergarten at five, where he was not interested in other children. After a while attendance was discontinued. His mental age at 5-2 was 3½ years. A private tutor was hired for his education. He was anti-social, very determined, demanding, tense, over-active, hot-tempered and manageable only with diplomacy. He seemed to feel he was the center of the universe. He fanatically hoarded electrical insulators."

*Bailey Hall, Katonah, N. Y.

Observation. "Wears glasses, features blank, scowls, squints and looks about aimlessly. Manipulates clothing clumsily, cannot tie necktie. No spontaneous speech at first but later asked intelligent questions. Pronunciation defective as, 'Fird riding artillery bigrade' for 'Third riding artillery brigade.'"

Opinion. "Mental retardation, congenital."

NOTE.—Unfortunately B. did not undergo any projective tests to determine the possible degree of emotional instability. It is extremely likely that the results of such tests would have altered the diagnosis of the case.

*Teacher's Report During Period of Observation at the School**

"B. is so hyper-sensitive that, if addressed in a raised voice or in a mildly critical tone, he flies into a rage or becomes painfully dejected. He rarely smiles and shows no interest in things going on about him. He manifests no desire to associate with any of the other boys; and, on rare occasions when he can be induced to join in their play, he is awkward, shy and a very poor loser. It is pitiful to watch him try to catch, throw or bat a ball. He is completely lacking in co-ordination and does not know what to do. He shrinks from all competitive sports and social activities.

"When entering a room with people present, he lowers his head and looks fixedly at the floor. On his own initiative he never engages in a conversation but sometimes answers blankly when addressed. He seems unable to look directly at the person but turns his eyes either to the floor or to one side, an unhealthy characteristic. He is always alone, usually changing his seat if any of the other boys happen to sit down beside him. He walks in a peculiar manner, head thrust forward and down, shoulders hunched up.

"He has one all-absorbing interest, a basket of electrical insulators. These have become so great an obsession that he refuses to part with them even at bed time and carries them with him all day long, like a very young child with a doll or other favorite toy. He is resentful and becomes hysterical if asked to put them aside for a few minutes or if anyone touches them.

"He enjoys automobile rides, and constantly demands, 'Are we going for a car ride? When are we going for a car ride? Are we going for a car ride now?' He is very persistent in this. His be-

*The writer was B.'s teacher and guidance counselor throughout the period covered by this report.

havior and bearing are very similar to that of a boy of low mentality."

Educational Achievement Before Admission to Special School

Until July 1940, B. had made very little scholastic progress. His best subject was reading. He read fairly well on a third grade level with good comprehension. However, he had considerable difficulty with enunciation. In arithmetic his performance was be-

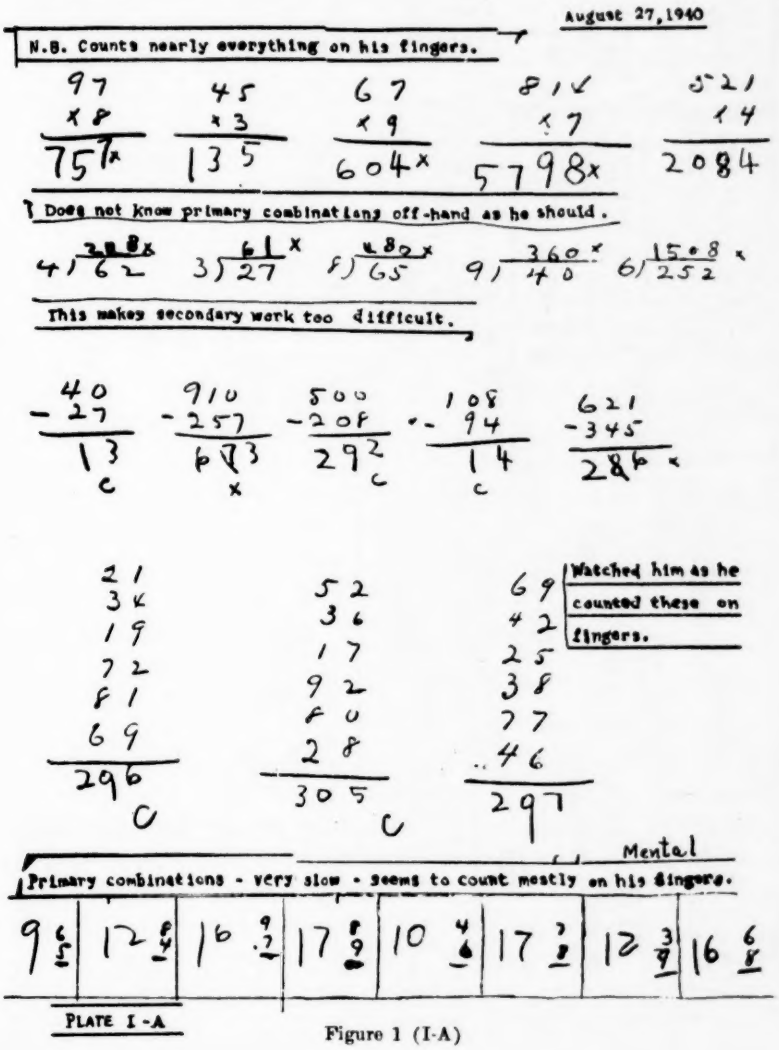


PLATE I-A

Figure 1 (I-A)

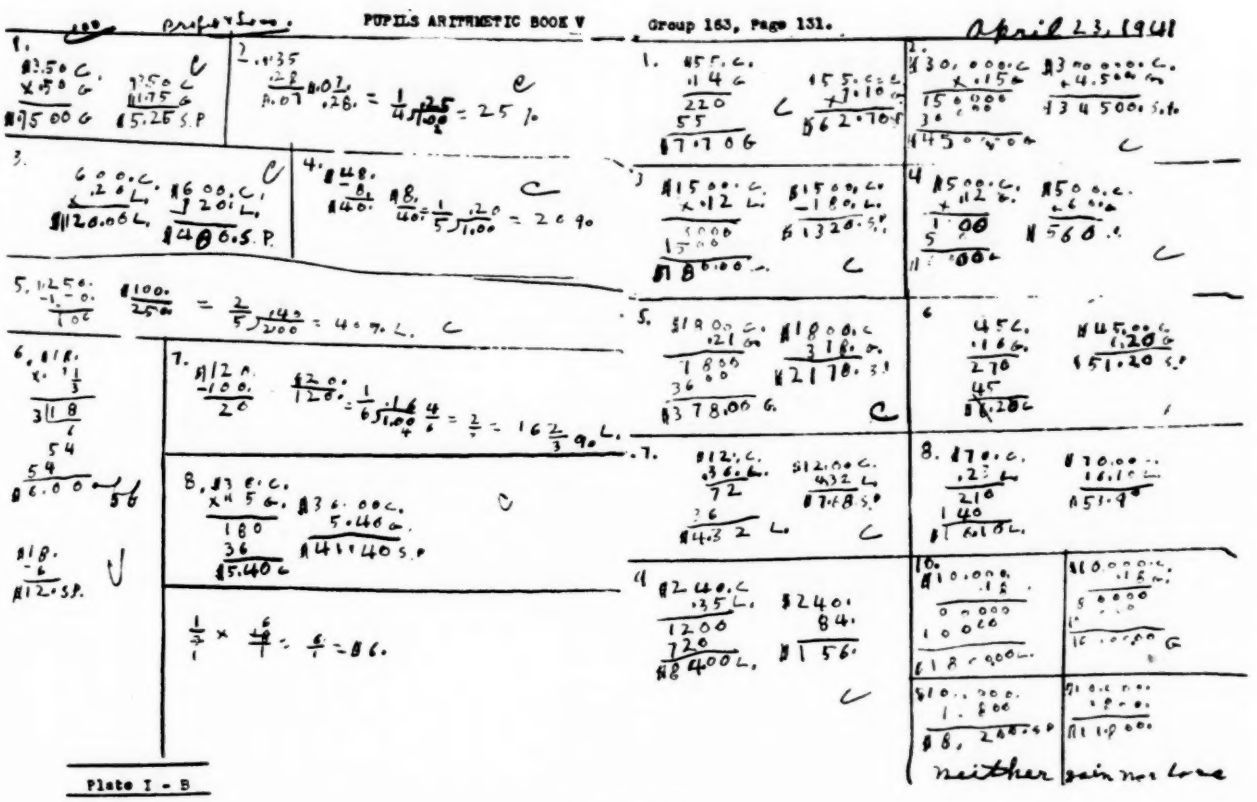

PUPILS ARITHMETIC BOOK V
Group 163, Page 131.
April 23, 1941
Plate I - B

Figure 1 (I-B)

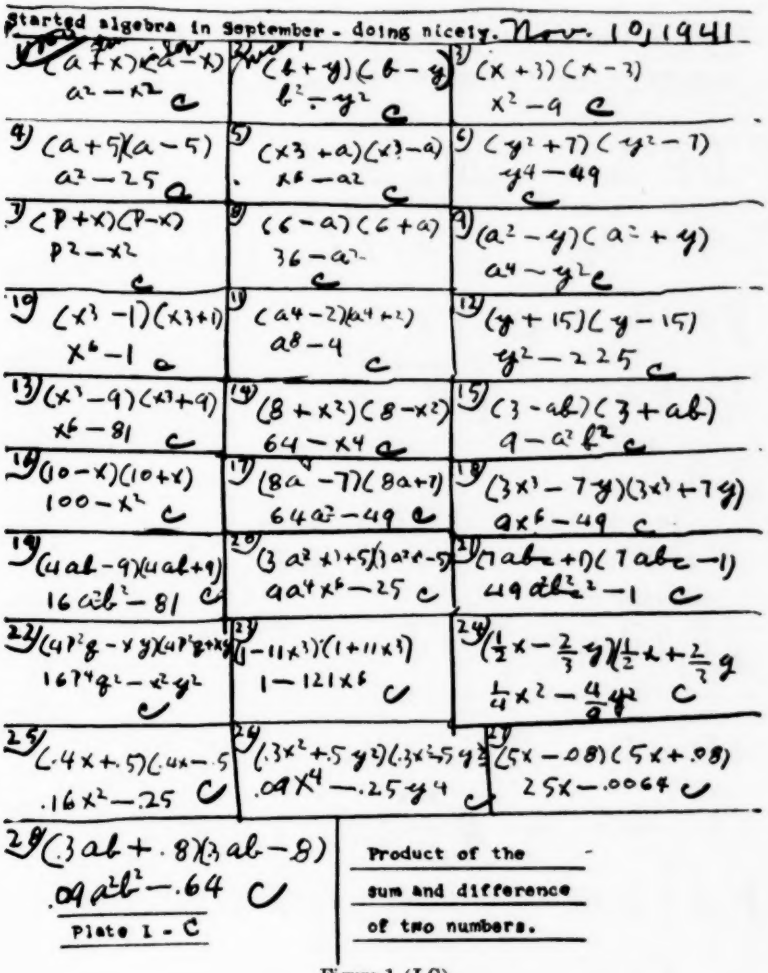


Figure 1 (I-C)

tween second and third grades; he used his fingers for counting (see Figure 1, plate I-A). His writing was on the kindergarten level. He was able to *print* some of the letters of the alphabet rather crudely but was unable to use cursive writing at all (see Figure 2, plates II-A and II-B). He could not print his full name or spell very simple words (see Figures 2 and 3, plates II-A, II-B, III-A, III-B). When he tried, for the first time, to print a short letter to his parents, he cried because the task was too difficult. Such was the picture presented by B. during the summer of 1940.

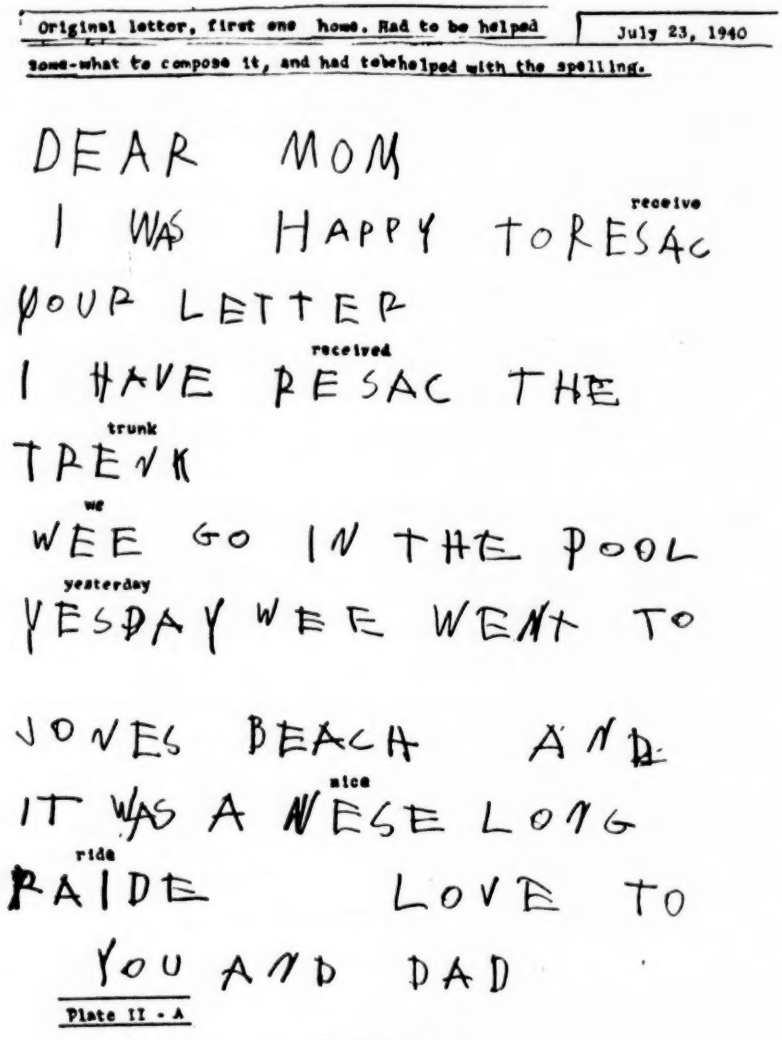


Figure 2 (II-A)

Analysis

Because of the lack of sufficient factual material concerning B.'s history prior to his admission to the school, and because no projective tests had been administered; the analysis, hypotheses and conclusions of this case are necessarily based on the few facts

August 18,1940

Original Letter

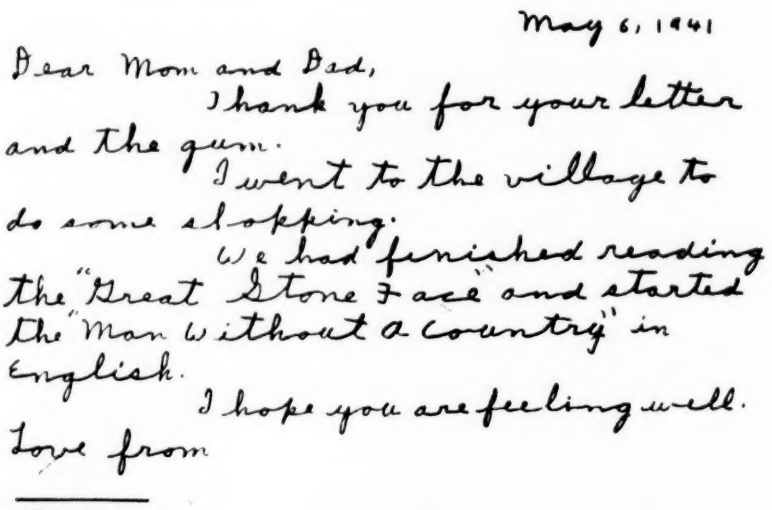
DEAR MOM AND DAD
WE HAD A MA Marshmallow SHMALLEA
ROST roast LEST last NIGHT
WE R are GOING ON A
PAPTT trip THIS WEEK
I WAS PLAVING PING ping PONG pong
AND SWESS shuffle BORD beard
I HAD BEEN WORKING
WIFD with MR
I RAASD received THELETTER
FROM YOU I WAS HAPPY
GET THIN them

Plate II - B

Figure 2 (II-B)

available, and on direct contact with, and observation of, the boy during his five years of school residence. The period covered is from July 1940 to June 1945.

B.'s hypersensitivity was probably his chief handicap from earliest childhood. He might have overcome, to some degree, his poor motor co-ordination if the emotional sensitivity had not interfered. This sensitivity was one manifestation of a congenitally neurotic


May 6, 1941

Dear Mom and Dad,

I thank you for your letter and the gum.

I went to the village to do some shopping.

We had finished reading the "Great Stone Face" and started the "Man Without a Country" in English.

I hope you are feeling well.

Love from

Plate II - C

Figure 2 (II-C)

disposition. When B. could not face social situations, he withdrew from them. He could not "take it," and was therefore given special consideration at home. This may have been the initial link in the chain of factors that brought about his condition of unbalanced behavior and mental retardation.

Inevitably, he stayed at home because other children would not spare his feelings. This, in time, led to intense introspection, abnormal introversion, detachment from his environment and a morose disposition. By leading a secluded, sheltered life as a child he was conditioned into an abnormal personality of a very serious degree.

By the time he was old enough to attend public school he had already created a tremendous barrier between himself and society. When his teachers reported (to his parents) that he was "intractable, anti-social, un-co-operative and could not learn," it was decided to keep him at home, and a private tutor was hired. Thus again, he had no playmates, faced no healthy competition, was deprived of normal contacts. His feelings were being spared, he was being sheltered for apparent security, but his mental and emotional growth were being stunted and warped. The desires for companionship and for excelling were present in the child but were seriously repressed.

Despite the fact that this added security of the home was given, B. still seemed unable to learn and progress like other boys, probably because the usual educational approach applicable to normal children was employed, and because a proper analysis of his condition was never made. He simply was unable to learn to write, spell or do arithmetic. The writing disability made it impossible for him to take notes or examinations and so he made little progress in the social studies. His lack of motor co-ordination and self-confidence deprived him of any opportunity for participation in social recreation. He was thwarted at every turn. No wonder, then, at his unhappy disposition! No wonder that he lost all interest in school, friends and other important aspects of a normal life!

B. had come to the stage where he would make no effort whatsoever. It was much easier to do nothing than to face the burden involved in learning or socializing with others. What few attempts he had made ended in failure, and one failure had led to another, each experience intensifying his aversion for contacts with the world. By the time he was 13 he was suffering from a deeply-rooted feeling of inferiority. He had learned to protect himself by adopting a pattern of bitter *"nervous resistance,"* opposing or disregarding all normal activities, taking the line of least resistance and being content merely to exist. This was his defense mechanism. It may be pointed out here that, had this boy been mentally defective, his personality would not have been so deeply affected by his apparent disabilities.

At home, his brother and sister were leaving him far behind scholastically and disregarding him socially. They were going about their own business and would not be bothered with him. This added further disappointment. They did things, had fun. They succeeded. He once remarked, "I couldn't do anything they could do, so I got mother to drive me around in the car." This was one way of escaping from reality, but it was not enough. He was lonely, had nothing to do; so he bought and collected a basket of insulators to take the place of friends—and he clung to them tenaciously. He did, however, understand their practical uses. The substitution of this type of activity for friends is not commonly found among mentally deficient children.

As the years went by, B. became more and more peculiar. He felt hopeless, acted hopeless and looked hopeless. Step by step

his condition had deteriorated. It seems quite certain that in a few more years he would have become an abnormal, completely dependent adult.

Procedure and Treatment

By the end of 1940, five months after his admission, it appeared that B. did have sufficient intelligence to make good academic progress; and it was discovered that, buried deeply within him, were also the normal desires for praise and success. Ways had to be found to tap these all-important basic urges. Faith in himself, courage and ambition had to be instilled and nourished. By proving to him that he could do well, yes, even better in some ways than other boys, his defensive shell might be penetrated, and his repressed, unhappy personality might be freed so that he could be guided into a normal, happy life.

This psychological and emotional change had to be brought about gradually, almost imperceptibly, to overcome his pattern of *resistance* and the "It's no use" attitude caused by frustration. He was not to become aware that everything was reduced to its simplest form to insure his success, otherwise the plan might have failed.

When, during the first few weeks, he would cry, "Must I do arithmetic? Must I do spelling?" he was gently told that he did not have to do anything; that he might do what he pleased in the classroom. So B. promptly proceeded to do nothing at all, as was expected. According to plan, the teacher turned his attention to the other children and developed an interesting arithmetic lesson by using several original devices. Soon some friendly competition developed, involving a few concepts in simple arithmetic problems which were rather easy for B. Until then he had seemed completely detached; but gradually he began to show some interest, as was indicated by changes in his facial expressions. Before long he was taking part in the lesson. He must certainly have been listening, and, in spite of himself, he could not help wanting to "show off" a little.

Since this technique worked, similar lessons were developed daily in the various academic subjects. The work was kept interesting, usually in game form and so graduated that the scores were always close, but B. invariably won. Slowly but *spontaneously,* he took an increasingly active part in all of the studies and pro-

jects without becoming aware that these procedures had been devised primarily for his benefit. This was an important factor because, at the time, he could not be asked directly to do "this" or "that." Fear of failure seemed to paralyze his thinking to such a degree that, in self-defense, he would resist formal instruction (an emotional block).

All the exercises in the foregoing lessons were things B. *could do* and some of the other boys, who were mentally deficient, *could not do.* The teacher was *always aware of this boy's reactions,* and

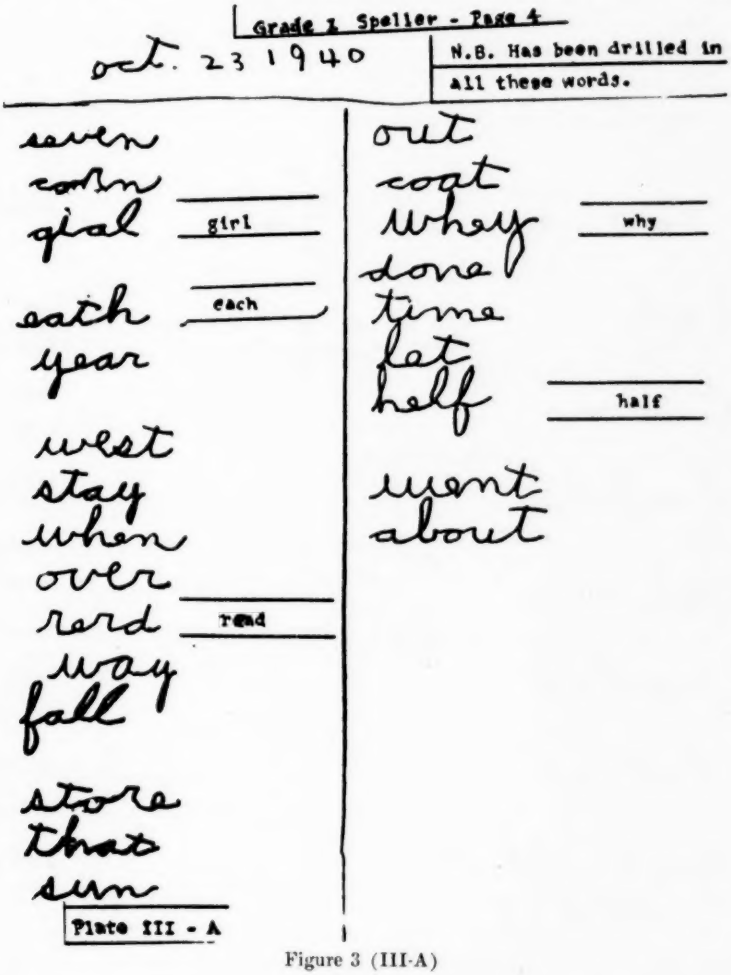


Figure 3 (III-A)

Spelling. August 27, 1940 .

N.B. Started to print but was told to use script.
This after weeks of practice.

SHIRT		shirt
milk		milk
mita		write
shoes	shoes	shoes
hat		hat
	coffee	coffee
coat		coat
	hair	hair
table		table
	hands	hands
chair		chair
	face	face
radio		radio
letter		letter
gail glul		girl

Plate III - B

Figure 3(III-B)

the work was planned to draw his active interest through circuitous ways rather than by direct instruction. Thus, his resistance to study and competition was overcome in the classroom.

Within a few weeks, he was tutoring some of the less capable pupils—which helped to build up his ego and enabled him to acquire information and classroom skills more rapidly. But the chief result was that the *feeling of success* began to take root at this

Figure 3 (III-C)

99. Page 27
13th to 14th week

N.B. Plates III-D and III-E indicate an advance of four years, in a period of six months.

July 30, 1941

1	especially	20	fourteen
2	usual	21	killed
3	district	22	rings
4	pleasant	23	sure
5	practicing	24	anyhow
6	decided	25	tie
7	spare	26	orange
8	maid	27	birds
9	~~Roo~~ nose	28	Christmas
10	visited	21	Mountains
11	visitors	30	rive
12	stone	31	seemed
13	cleaning	32	expecting
14	grown	33	period
15	groan	34	daily
16	frame	35	numbers
17	dressed	36	match
18	sometimes	37	stuff
19	worst	38	nurse

Plate III - D

Figure 3 (III-D)

time. At long last he was the *master;* no longer must he constantly accept defeat in the role of the underdog. Soon he did not have to count on his fingers and his progress in arithmetic became very rapid (see Figure 1, plates I-B and I-C). Here, then, was the beginning of the penetration of his defense mechanism.

By continuing such educational and psychotherapeutic methods his teacher was able to instill in B. the self-confidence he needed. Because the main objective for the first few months had been that he should succeed remarkably well in everything he undertook, the groundwork for his learning and emotional stability was successfully laid. When B. began to work eagerly, he was taught to write legibly (see Figures 2 and 3, plates II-C and III-A to III-E) and to study effectively, with the result that he began to learn with surprising ease. He was so thrilled that, for the first time in his life, he showed pride in his work. Soon he was greatly spurred on by desire to gain the approval and recognition of the school staff, and he gradually became imbued with a growing desire to succeed. Here indeed was a true example of, "Nothing succeeds like success." It now became possible to utilize normal educational procedures in his case.

By the end of his first school year, there was such a profound change in the boy that his physician gave his parents a most optimistic report. At this time the Stanford-Binet, Form L, Mental Test, was administered by the school psychologist, and B. scored an IQ of 103.9. Within two years his scholastic performance was on a par with his chronological age and far beyond his original mental level (IQ of 68). The writer is convinced that B. had always possessed normal intelligence but had tested low because of his serious emotional and personality blocks.

The boy's extreme spelling disability, previously mentioned, was also corrected. He apparently had little or no phonetic sense and therefore could not learn to spell by the usual methods. Further analysis revealed several other probable contributing causes for this difficulty.

First, his enunciation was very poor. He could not produce the sounds for V, F and TH correctly. He could not discriminate between the sounds of M and N and had difficulty with several other letters. This condition may have been due, in some measure, to the nature of his jaw and teeth formation. For this reason, he may have been unaware of incorrect phonetic sounds, a factor

Pages 59 and 60

10/ 24th and 25th weeks

Dec. 3, 1944

	materials		superior
1	catalogs	20	column
2	thorough	21	instruct
3	design	22	advertisement
4	sketch	23	prior
5	piano	24	children
6	medium	25	membership
7	represents	26	numerous
8	recovered	27	destroy
9	notion	28	scarcely
10	tried recent	29	since
11	reception	30	explaining
12	advantages	31	reduced
13	patience	32	slightly
14	inquire	33	guest
15	cellar	34	using
16	expensive	35	patient
17	guard	36	requests
18	painting	37	trace
19	consent	38	constitution

Plate III - E

Figure 3 (III-E)

which, in turn, interfered with his learning to spell. He received orthodontal treatment and speech exercises to aid in overcoming these handicaps.

A second possibility was that he had not developed sufficiently keen auditory perception because he rarely talked to people. Thus, he often mispronounced words under the impression that he was pronouncing them correctly. As time passed and his social contacts increased, this condition was vastly improved.

Then the question arose as to why he was unable to spell even those simple words that he could read and use correctly in speech? It was discovered that his eye took in whole words only, at a glance; that he had not learned how to focus on syllables or individual letters. He could not hold his vision on one spot. This proved to be the most important single cause of his spelling deficiency. By utilizing original methods and devices, he was taught to *focus his vision* and fix his attention on the syllables and specific letters. Thus, for spelling he developed, one might say, a spelling or focusing vision, while for reading he used the natural, sweeping eye movements. In addition to this training he received instruction in phonetics. By such means B. learned to spell as well as the average student (see Figures 2, 3 and 4, plates II-C, III-D, III-E and IV-B).

The following incident should be related. One day in December 1940, while B. was still in the developmental spelling stage, a high school teacher of English was a guest at the school. After observing B. for about 15 minutes, he remarked to B.'s teacher, "Don't you think you're wasting your time? Anyone can see that this boy will never learn to spell." Approximately 18 months later, B. passed the New York State Regents examination in spelling with a grade of 93 per cent. This incident points up the fact that if standard methods and procedures had been used, the guest's prediction might well have been true.

But academic progress alone would not have solved B.'s problems. His remarkable scholastic progress was used as a stepping stone toward his personality development as a whole. Obviously, it was necessary for him to socialize, to play with other boys, to engage in group and competitive games, and to learn to get along with people before he could be reclaimed for society. This phase of the program required untold patience and planning, because at this point in his development it was extremely difficult for B. to

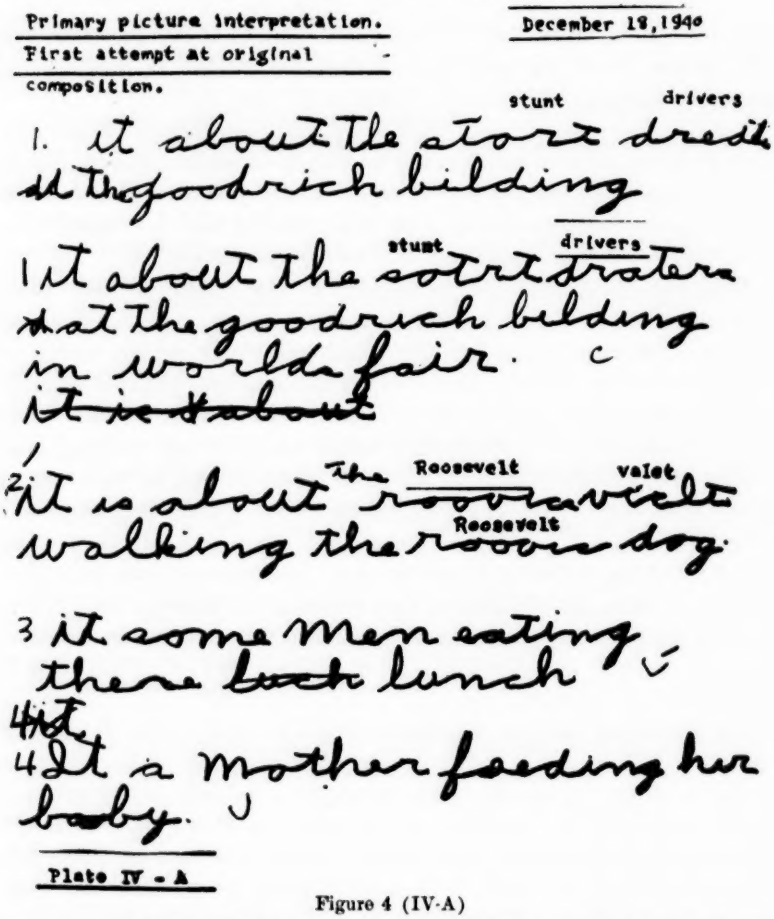


Figure 4 (IV-A)

participate in anything other than his studies. His splendid success in the classroom, however, seemed to have been just the wedge needed to get him started in other activities.

It was decided to introduce B. to the game of shuffleboard. For him, it offered an ideal means of psychotherapy through play therapy. It does not require the skills or the co-ordinated team work necessary for baseball, basketball or football; but it is a sociable and friendly game. As was previously the case in the classroom, B. had to start with something that was very simple in order to insure success, and yet something that seemed important—or seemed more advanced than it really was. Shuffleboard was the ideal type of game for the purpose.

95 Primary Picture Interpretation

Nov. 6, 1941

1) Three girls having a race and other girls are watching them. 10

2 A soldier is pressing his uniform with an electric iron. 10

3 a mother with her daughter shopping in a self service market. the mother is pushing a cart with baskets on it filled with groceries.-

3 A mother with her daughter are shopping in a self-service market. The Mother is pushing a cart with baskets on it filled with groceries. 10

4 An artist is painting a picture of the mountains in the background. 10

5 Some Monkeys holding their babies 10

6 A man is playing a piano and people are dancing.-

Plate IV - B

Figure 4 (IV-B)

After a number of private lessons on the court, he was able to manipulate the cues well enough to join in a game with some of the other boys who (as planned) could not offer stiff competition; and much to his surprise, B. won. He actually could beat other boys in competition! His joy knew no bounds. As he became imbued with a feeling of confidence, his inferiority feelings underwent a process of dissolution. Soon he began to practice on his

own initiative. Some time later an elimination tournament was planned for his benefit, and B. found himself in the top rank. This marked the turning point in his socialization. He no longer disappeared or retired into seclusion when shuffleboard games were started. He was quite confident now. Play and study became incentives, not dreaded tasks from which to escape.

Of course all kinds of stratagems again had to be employed to get him to play baseball, basketball and football. They proved to be very difficult for him. At this stage, his hypersensitivity was still evident but he was able to control it to the extent that he could participate. He began with individual lessons in catching, throwing, batting and kicking, ostensibly for pastime. Then, after he had acquired some degree of proficiency, he gladly helped the younger children in these activities. In this way, he received additional practice without undermining his ego. After several months of this routine, he decided to join in the regular games. He did not play well but he did play, and he made progress. When he hit the ball out of the infield or kicked the football over his opponents' heads, he showed the glowing satisfaction which his repressed emotions had been craving these many years.

In June 1942, two years after his enrollment, B. took the eighth grade New York State Regents examinations at the local public school. The following were his marks: English—96 per cent; spelling—93 per cent; silent reading—89 per cent; history—97 per cent; geography—99 per cent; arithmetic—100 per cent; elementary algebra (first year high school)—93 per cent. His progress had been such that it was felt he was ready to participate in a normal environment, and in September, B. was enrolled in the local high school.

Attending high school would give B. an opportunity to adjust to a normal situation and to perfect his social behavior; but, even here, he required special preparation. Partly to make up for his lack of athletic prowess and social aptitude, he was taught some Latin, science and intermediate algebra during the summer so that he might, perhaps, win some respect and friendship from the other students by being able to help them with their studies. It was essential that he should not be repressed and emotionally depressed because of any possible poor social adjustments.

As was anticipated, he was aiding several of his classmates in their studies within a short time. This led to social acceptance,

and on several occasions he was invited out. Thus, psychotherapy, through adequate preparation for each new situation, was constantly being applied during this important phase of his development.

The success of these methods was evidenced by B.'s achievements, socially and academically, in high school. When the scrap metal and rubber drives were on during World War II, B. was selected for the high school committee responsible for the success of these drives. This kindled a tremendous interest in him, and he spent much of his spare time with the other committee members, gathering tons of scrap. When the drive was over, he had been instrumental in the delivery of over five tons of scrap metal and large quantities of scrap rubber. Even his cherished insulators were spontaneously and gladly sacrificed to the scrap heap! He was a happy boy when he received honorable mention for this work at the high school assembly.

As a freshman, B. was president of his class, a delegate to the student council and an honor student. During his sophomore and junior years, he was assistant manager of the football team, in charge of the locker room and athletic supplies. He completed the entire high school course in three years, having taken a more difficult program than the average student. His major subjects included: English, four years; Latin, three years; social studies, two years; general science; chemistry; physics; algebra through advanced; geometry and trigonometry. He won the chemistry medal, and his average in the regents examinations was above 90 per cent.

By his junior year he had almost overcome his shyness and sensitivity. He had made many friends and even went bowling, although he was still rather awkward. His ambition was to become a chemical engineer. How different from those insulator-collecting days!

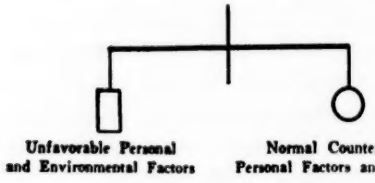
B. was 18 when he received his high school Regents diploma. He had caught up to his age-grade. He applied for admission to the school of chemical engineering of a large, eastern university and was accepted.

Conclusions

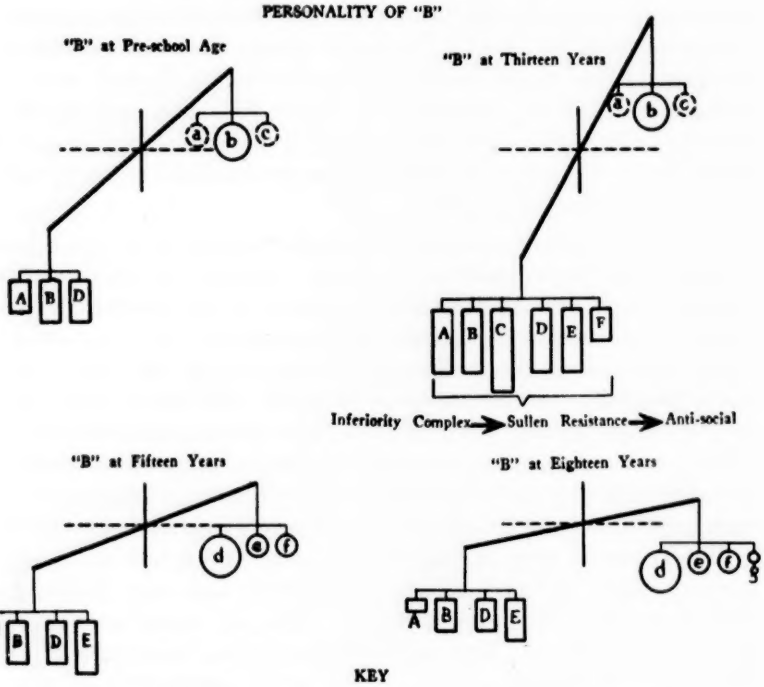
It may be stated that the case of B. presents the problem of a maladjusted personality which was manifested by a neurotic predisposition, extreme hypersensitivity, feelings of inferiority,

DIAGRAMATIC PRESENTATION OF PERSONALITY

A NORMAL BALANCED PERSONALITY



PERSONALITY OF "B"



KEY

UNFAVORABLE FACTORS

A. Hypersensitivity
B. Social Inaptitude
C. Scholastic Failure
D. Lack of Friends
E. Athletic Inaptitude
F. Poor Neuro-muscular Co-ordination

FAVORABLE FACTORS

a. Desire for Approval
b. Intelligence
c. Desire for Social Acceptance
d. Scholastic Achievement
e. Self-confidence
f. Ambition
g. Success in Social Adjustment

Potential, Latent, Favorable Factors

PLATE V

Figure 5 (V)

social withdrawal and apparent mental deficiency. Through effective psychotherapy and special educational procedures the tremendous personality imbalance was checked and gradually offset until B.'s personality adjustment approached the normal. Figure 5 (plate V) contains a diagrammatic presentation of the transformation of B.'s personality as compared to a normally balanced personality.

This case study leads the writer to believe that serious maladjustment problems in children can often be corrected by the effective use of psychotherapeutic methods and suitable educational procedures; that every personal effort is a potentially worthwhile human investment; and that a thorough, personal exploration and analysis of each case is necessary if the problems involved are to be overcome. Though the same general methods of treatment can often be applied, the specific manner of approach will vary with the individual, since no two problems are alike; nor do any two instructors, psychologists or psychotherapists have the same abilities or personalities. Every effort must be made to anticipate and prepare the child for possible difficulties and frustrations. One should be fully aware that the plans and methods must *fit the child* and not make the error of trying to fit the child into fixed plans and methods. This latter effort may be one of the causes of the child's problems. Every successful achievement in this area of human adjustment is a blessing to the child, his family and the community, and leads to further knowledge in the fields of both psychotherapy and education.

SUMMARY

This article presents the case history of an adolescent boy who was apparently mentally deficient. At the age of 13, a failure scholastically and socially, he was enrolled at Bailey Hall, Katonah, N. Y., a special school, and placed under the guidance and educational supervision of the author. Within a period of five years, this boy advanced from the second grade of elementary school to graduate with honors from the local public high school. The article presents the psychotherapeutic and educational methods utilized in transforming this apparently mentally deficient boy into a successfully balanced individual.

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HINTON ROWAN HELPER—A STUDY*

BY JAMES H. WALL, M. D.

From time to time in reading American history, one comes across a personality whose influence was great and widespread, but who, because of various circumstances, has been almost forgotten except by careful students of his period. We all know of John Brown and Harriet Beecher Stowe. The drama of their lives and work has caught the imagination of the American people. But the writer would like to discuss here another American whose influence probably did more to shape history than either John Brown's raid or *Uncle Tom's Cabin.* Brown surely caused no one to lose office, even though he did cause Robert E. Lee to be aroused from his bed early in the morning to quiet the unpleasantness at Harper's Ferry. Lincoln called Harriet Beecher Stowe "the little lady who started this great war," but the man who is the subject of this paper dismissed her with a few words in 1857: "Yankee wives have written the most popular anti-slavery literature of the day. Against this we have nothing to say; it is all well enough for women to give the fictions of slavery; men should give the facts."** And no less a person than John Sherman of anti-trust fame, a younger brother of the general, lost the position of Speaker of the House because he endorsed a book written by the same man.

This is to introduce to you Hinton Rowan Helper, born in the Yadkin Valley of North Carolina, a part of the South so beautifully protrayed in Ben Ames Williams' recent novel, *House Divided.* He is so little known that some careless authors of history textbooks class him among the poor whites of the South, much to the annoyance of his surviving relatives. His German grandfather, Jacob, whose family name was Helfer, had settled in this fertile valley in the mid-eighteenth century, and his mother, Sarah Brown, came from one of the most substantial families in the section, which had started the tobacco industry in Winston-Salem. Although not a wealthy man, his father, Daniel, owned and managed successfully a fairly large plantation and owned several slaves who were liberated by his will.***

*Read at the Vidonian Club, New York City.

**Helper: The Impending Crisis, preface.

***Biographical History of North Carolina, p. 205.

Hinton, who called himself his father's "youngest, homeliest and most mischievous son,* was born on December 27, 1829 in Davie County, N. C., the youngest of seven children, five sons and two daughters. An interesting footnote tells us that the names of all his father's children started with H and those of all the slaves, with J. His father died when Hinton was only nine months old, and the family fortunes suffered a severe setback. He remained deeply attached to his mother, whom he described as a "beautiful blue-eyed damsel,"** and in later years he recalled that he was "certainly a close clinger to the breast, a source of sweet solace and sustenance."*** His older brothers declared that he did not desert that "sweet source" until he was at least six years old.

His early childhood was like that of other backwoods boys: rough sports, hunting, fishing, farm work and a little schooling. He was not robust as a child, but he grew to be an admirable specimen of manhood.† Among the people of his childhood whom he remembered dearly were his black nurses and playmates, Judy, Jensy, Jo and Jack.‡

He was a very religious boy, who twice read the family Bible through and who declared that he had read the stories about David and Solomon about "three dozen times."†† Most of his early education was received under the kindly and efficient tutelage of Peter S. Ney, the almost legendary schoolmaster whom many believe to have been Marshal Ney, fled to America after the downfall of Napoleon. He was graduated from the Mocksville Academy in North Carolina at the age of 17, in 1846.†‡ After his graduation, he was taken to Salisbury, N. C., a town made famous by Andrew Jackson, who had been the leading attorney in that area before he migrated to Tennessee. At this time, Hinton had an experience which became the point of attack of all his enemies throughout his life and afterward. His uncle, Michael Brown, obtained a position for him in a drygoods store in Salisbury; and later it was claimed that he had stolen $300 from his employer. In later years, a critic of his book and life called him "this foxfire philosopher, luminous only

*Helper: Nojoque, p. 12.
**Ibid., p. 11-12.
***Ibid., p. 13.
†Johns Hopkins Studies, 16 Ser., No. 6.
‡Helper: Noonday Exigencies in America, p. 156.
††Helper: Nojoque, p. 12.
†‡Biographical History of North Carolina, pp. 204-5.

from his putrescence, upon the principle that a rotten mackerel shines by moonlight."* In talking with some of his descendants and friends in that part of the state, the writer gathered that it was a common custom for a young clerk when he was employed at the salary of $20 a month, to bow politely and say, "Yes, sir, and I'll take $20 a month." Later, Helper explained to Horace Greeley that he actually had received the $300 as a loan and had signed a note for that amount, which he had later repaid.**

After this episode, Helper went to New York City and joined the great movement to California, going there by ship around the Horn. Recently, Lucius Beebe has brought Helper's account of this trip to our attention in a new and popular edition called facetiously *Dreadful California*. The book was first published in 1853 under the title, *The Land of Gold, Reality vs. Fiction*. Helper was astounded by all he saw there. The drinking and immorality were most shocking to him. He said that California would be helped by an influx of the "chaste wives and tender mothers who bless our other seaboard."***

In 1854, at the age of 29, he returned to the family plantation in North Carolina, and found life so stagnant there that he became actively interested in studying what appeared to him to be the deterioration of the South.† He began writing the book by which he is remembered, *The Impending Crisis of the South: How to Meet It*.

This book was stimulated by his observation of free labor in California and by his reading of Thomas Jefferson's views on slavery. It grew out of his study of the 1850 census, in which he contrasted the economic conditions of the free states and the states whose economy was based on slave labor. He attributed the backwardness and economic deterioration of the south to the impoverishment of free labor by slavery. He attacked the slaveholders and predicted an uprising of the slaves. It is interesting to note that some of the more recently published documents of the period show that other intelligent southerners felt as he did about the situation,‡ although they did not publish their observations at the

*Beebe: A Review and Refutation of Helper's "Impending Crisis," p. 23.
**Lefler: Hinton Rowan Helper, p. 32.
***Helper: Land of Gold, p. 44.
†Johns Hopkins Studies, p. 12.
‡Chesnut: Diary from Dixie, p. 21.

time. Not infrequently slave-holding masters and their wives had been murdered in their beds by their trusted slaves.* We must remember that the reason the South was so bitter about John Brown's raid, regarded in the north as a crusade, was because it threatened to start the very thing slaveholders dreaded most, a slave insurrection. The governor of Virginia, Roger Pryor, went so far as to blame the raid entirely on Helper's book.**

On his way north to seek a publisher, Helper stopped at Baltimore, hoping to receive help from one of the first Republican organizations of the South, but he did not succeed. The book was rejected by many reputable New York publishers, who did not wish to lose their southern trade.***

It was finally published in New York City by A. C. Burdick in 1857, that is, four years before the beginning of the Civil War. It ran to 144 editions. Apparently no one saw that one of the main purposes of the book was to restore economic progress in the South through employment in agriculture as well as in industry of the many poor or non-slaveholding whites, who certainly outnumbered the aristocratic plantation owners, but who were in a financially insecure position. In the north, the book became another Bible of the abolitionists, and in the South, it and its author were roundly hated by the slaveholding class.

Helper showed, by means of convincing statistics, how the South was deteriorating economically, in contrast to the prosperous free-labor north. He urged that the slaveholders pay $60 for each slave, this sum to be applied to African colonization. "Let every slaveholder give $60 in currency. Let us charter all the ocean steamers and clipper ships that can be had on liberal terms and keep them constantly plying between the ports of America and Africa until the slaves shall enjoy freedom in the land of their fathers."†

He had no idea of reimbursing the slaveholders, whom he regarded as thoroughly reprehensible, for the loss of their property. He was reviled throughout the South. Those who favored him were spoken of as Helperites, his books were burned, and Helperites were jailed and dismissed from their jobs. Three men were

*Ibid., p. 139.

**Seitz, Uncommon Americans, p. 251.

***Lefler: P. 19.

†Helper: Impending Crisis, p. 183.

hanged in Arkansas for owning the book, several preachers were driven from their pulpits for endorsing it, and, throughout the South, seven laws were passed against owning or reading it.* Helper was called a thief, a liar and a traitor to his native land. It became necessary for him to move north permanently.

In 1859, the book was widely circulated as Republican campaign literature. It has already been noted that John Sherman's endorsement of it cost him the speakership of the House.** It has been said that *The Impending Crisis* and *Uncle Tom's Cabin* combined did more to destroy slavery than any other force.*** Horace Greeley in the *New York Tribune* gave *The Impending Crisis* the longest review any book had ever received in an American paper up to that time.†

As a reward for Helper's work, which had inadvertently helped the Republican Party, and probably also for the sake of his personal safety, Abraham Lincoln appointed Helper consul in Buenos Aires in 1861.‡ He evidently had his difficulties in this post. He had to borrow money, and frequently his accounts were short.†† Here also he began his violent attacks on the Catholic Church, of which he wrote, "The bigoted fanatical adherents of the befooling and baneful religion of Rome, body-degrading, mind-debasing and state-destroying system of theology,"†‡ but in the face of this opinion, he was married by a priest to his Catholic wife, Maria Luisa Rodriguez, who renounced her inheritance for him.‡‡

He returned to this country in 1865 and was amazed to see how his book had been misunderstood. At this time he turned violently against the Negro and began to write polemics against the race. Much of what he said recalls the insane outpourings of Hitler in our generation.

Helper wrote several books on the subject: *Nojoque* in 1867, *Negroes in Negroland* (1868) and *Noonday Exigencies* (1871). (Notice again the family use of repeated initials.) He became an advocate of white supremacy and spoke of a "freer white and

*Seitz: P. 250.
**Dictionary of American History, Vol. III, p. 25.
***Pelletreau: Hinton Rowan Helper, p. 802.
†Lefler: P. 19.
‡Pelletreau: P. 807.
††Lefler: P. 35.
†‡Helper, Oddments, (Dedication).
‡‡Lefler: P. 35.

higher civilization in the new world." He described the Negro as a menace to white labor and vowed "to write the Negro out of America and out of existence."* He spoke of "the negroes, Indians and Chinese and other obviously inferior races of mankind whose mental and moral characteristics are no less impure and revolting than their swarthy complexions. All persons who are not white are as an innate and inseparable condition of their existence, drones and sluggards and vagabonds of the worst possible sort."** He advocated complete segregation, to the point where he refused to patronize hotels and restaurants where Negroes were employed —this in the face of his childhood friendliness for the family slaves.

In writing at this same period on the development of some of the South American countries, he showed a further inconsistency. He felt that Nicaragua could never fulfill its destiny until it introduced Negro slavery. But when he was in Buenos Aires as consul, he refused to give American papers of protection to a Negro, his excuse being that the United States was already burdened with 4,000,000 too many Negroes. His hatred for the whole race was summed up in the statement that "the indestructible plan of Providence" for exterminating the Negro must not be interfered with by the whites.***

It is not surprising that the Radical Republicans in Congress, who were then in the midst of their reconstruction program in the South, should have considered him a traitor or worse. Some of his contemporaries even doubted his mental balance. His espousal of the cause of women's suffrage encouraged many more to question his sanity.†

On the other hand, he had friends who considered him a man of unquestioned ability, great quickness of perception, and dauntless courage.‡ He counted among them many of the leading thinkers of his day. This distinguished personality, tall, dignified, white-haired and bearded, with blue eyes and a florid complexion,†† greatly resembled Charles Evans Hughes in appearance. He was frequently seen on the streets and in the public buildings of Washington and other cities in the latter part of the nineteenth and

*Helper: Nojoque, p. V.
**Ibid., p. VII.
***Helper: Negroes in Negroland.
†Lefler: P. 14.
‡Biographical History, p. 214.
††Lefler: P.42.

early part of this century. He rose early, took long walks, ate infrequently and returned home late at night, having spent the day trying to impress his ideas on members of Congress and other public figures.*

Following the Civil War and during the reconstruction period, he spent his fury in an attempt to write the Negroes out of existence. He had continued to be interested in South America, and he advocated the establishment of regular steamship communications and the building of canals. More and more, as other American builders became absorbed in transcontinental railroads, communications and western expansion, his time and thought were taken up with plans for promoting a railroad from Hudson Bay to the Straits of Magellan. His principal reason for this, an outgrowth of his feeling of white superiority, was that the "backward," dark and Catholic peoples of South America would benefit greatly from increased contact with the progressive and enlightened North.

Not finding sympathy and support in Washington, he moved to St. Louis, and in 1879 he offered prizes of $5,000 each for the best essays and poems on the subject. Later, in 1881, he published five of the papers as a book, *The Three Americas Railway.* He was obsessed and driven by the idea, interviewed many influential men, wrote thousands of letters, memorialized Congress and called himself "the new Christopher Columbus." At different times he attempted to interest Morgan, Carnegie and Rockefeller, and in his later life it was said that he accused Carnegie of stealing his ideas. Many people believed that he spent his wife's money on the railroad enterprise,** but it is now known that his family in North Carolina helped him defray the expense of his publications and the awarding of prizes for the essays. He spent $70,000 on the Three Americas Railway scheme.***

In preparing the present paper, it was the writer's pleasure to interview several of Helper's relatives, among them a niece who had lived with him and his wife for a year in New York. They looked upon him as a dreamer, a genius who really did not know the value of money, and who thought that the government owed him support for the carrying out of his brilliant ideas.

*Charlotte Observer, April 18, 1909.
**Lefler. P. 41.
***Seitz. P. 255.

As Helper grew older, he became embittered and disappointed. In 1899, his wife, who had become blind, was sent back to her relatives in Buenos Aires, to be cared for by her family there, as he was no longer able to support her. The couple had no children. He continued to live in Washington and attempted to borrow money from all his old friends. He finally killed himself by asphyxiation in a cheap rooming house on Pennsylvania Avenue on March 9, 1909.

One newspaper noted of his passing: "The world had wrestled with him and thrown him. His mind was shattered and his heart broken. He took his own life and died at the age of eighty, this man who had shaken the republic from center to circumference and who, at a critical period, had held and filled the center of the stage."*

Helper was a man of strong opinions and always seemed to be against the prevailing trends and opinions of those with whom he lived and worked. His evaluation of the relative merits of free and slave labor has been vindicated by time. Certainly his native state, in which his father was a slaveholder, but which, because of its greater number of non-slaveholding whites, was looked upon as a "valley of poverty between two mountains of conceit," Virginia and South Carolina, has shown since the Civil War the greatest economic advance and industrial growth of any Confederate state. In this at least, he has earned our respect.

Helper's fanatical views on the race question and his general inconsistencies, on the other hand, form an interesting psychological picture. We see a man fighting against his mother South, although he did not relinquish the breast until a late age; loving his Negro companions as a child and hating the race as he grew older; hoping to better the laboring classes of the South and yet wishing to exterminate a large proportion of those who had labored so well; hating Catholics, yet marrying one; attempting to connect the three Americas by a railroad when all others were busy establishing communications within the United States; and in the fatigue, frustration and exhaustion of old age, turning against, and finally destroying, himself.

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*Louisville Courier Journal (in Lefler, p. 42).

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MONGOLISM

BY MARTIN LAZAR, M. D.

Introduction

This study is an attempt to reconsider some of the more common factors which have been previously mentioned in the literature as etiological in Mongolism, and to present the results of the studies. No attempt will be made to review the literature or to discuss the theories and symptoms, as there have been many publications since the original one by Langdon Down in 1866.

With the opening of Willowbrook State School on October 24, 1947, increased facilities became available in New York State for the admission of mentally retarded children under the age of five. On each of these children, a pre-admission anamnesis and abstracts from previous admitting hospitals were required.

Material

For the purpose of this study all Mongols under the age of five, admitted during the three fiscal years from April 1, 1948 to March 31, 1951 have been used.

During the fiscal year 1948-49 there were 41 male and 21 female Mongols admitted out of a total of 99 male and 59 female admissions. During the second year, 1949-50, there were 48 male and 28 female Mongols admitted out of a total of 190 males and 131 females. During the third fiscal year, 1950-51, there were 40 male and 31 female Mongols admitted out of a total of 182 males and 118 females. These are totals of 129 male and 80 female Mongols admitted out of 471 male and 308 female admissions. Male Mongols constituted 27.4 per cent of the male admissions and the female Mongols 22.9 per cent of the female admissions.

Table 1

Fiscal year	Male admissions		Female admissions	
	Mongols	Total	Mongols	Total
1948	41	99	21	59
1949-50	48	190	28	131
1950-51	40	182	31	118
	129	471	80	308

The age distribution of the children is shown in Table 2.

Table 2

Age	Male	Female
Less than 1 year	30	16
1-2 years	41	29
2-3 years	21	23
3-4 years	18	8
4-5 years	19	4
	129	80

Parental Ages

There were no extreme differences in ages between mother and father except for a small group. The age of the parents has been mentioned frequently in the literature as a contributory factor in Mongolism, the age of the mother being considered more important. Table 3 shows the distribution of the parents according to age and Table 4 the age differences.

Table 3

Age of parents	Father	Mother
Less than 20 years	3	7
21-30	41	69
31-40	110	96
41-50	34	20
Over 50	4	0
Unknown	17	17
Total	209	209

Table 4. Age Differences Between Mother and Father

Less than 1 year	22	13 years	0
1 year	28	14 years	1
2 years	30	15 years	1
3 years	63	16 years	1
4 years	22	21 years	1
5 years	16	23 years	1
6 years	12	24 years	1
7 years	7	25 years	1
8 years	11	34 years	1
9 years	7	Unknown	17
10 years	4		
11 years	1	Total	209
12 years	1		

General Health of Mother

The general health of the mother is always difficult to assess at any distance from the pregnancy. Many mothers complain of severe discomfort during pregnancy, but it is difficult to evaluate such complaints. Leaving out the problem as to whether the pregnancy was difficult or easy, the conditions shown in Table 5 were noted by the parents as having occurred prior to or during pregnancy.

Table 5

Fibroid tumors	1
Hypertension	2
Staining and hemorrhage	10
Anemia	4
Nervousness	1
Severe nausea	2
Kidney stone	1
Hypothyroidism	3
Epilepsy	1
Previous curettage	3
Use of "abortion pills"	1
Pneumonia during second month	1
Appendectomy during second month	1
Anesthesia at time of conception	1
Tuberculosis	1

Abortions

Thirty-nine of the mothers had had a total of 52 abortions prior to the pregnancy resulting in the Mongol child (Table 6).

Table 6

Number of mothers	Number of abortions	Total
32	1	32
4	2	8
1	3	3
1	4	4
1	5	5
—		—
39		52

If one were to consider the proportion of abortions to live births of Mongol children, this would result in a figure of 25 per cent. However, one must also consider the fact that there were pregnancies resulting in live births besides those resulting in Mon-

gols. Taussig states that the frequency of abortions is about one in two and one-half in urban areas and one in five confinements in rural areas. The figure, therefore, obtainable here would be within average limits, and in this material at least, a previous abortion cannot be considered an etiological factor.

Reduced fertility has also been given as a possible etiological factor. The time from the previous birth until the birth of the Mongol was considered here. Where the mother was a primipara, the time from marriage was taken. This latter figure is rather weak, because, in these cases, it could not be determined just when the parents had decided to have a child or whether any particular pregnancy was accidental.

Table 7 shows the distribution:

Table 7

Period of years from previous birth	Number	Period of years from previous birth	Number
Less than 1 year	12	9-10 years	4
1-2 years	34	10-11 years	3
2-3 years	29	11-12 years	1
3-4 years	33	12-13 years	2
4-5 years	22	16-17 years	1
5-6 years	11	17-18 years	1
6-7 years	12	Unknown	38
7-8 years	5		
8-9 years	1	Total	209

Religion

Fifty-eight of the children were Hebrew. One hundred three were Roman Catholic. Forty were Protestant, and in eight the religion was unknown. The distribution of Mongols according to religion (Table 8) compares closely with that of mental deficients as a whole in the institution.

Table 8

	Mongols	Total adm. of same religion	Percentage of total of same religion	Percentage of Mongols	Percentage of distribution of religion
Hebrew	58	200	29	28	25.6
Roman Catholic	103	390	26	49	50.0
Protestant	40	175	22	19	22.5
Unknown	8	14		4	1.9

Prematurity

In only 27 cases was prematurity of birth mentioned, and in 21 of these the statement was made that the child was born at the end of the eighth month. In six instances, birth was at the end of the seventh month. All other cases were stated to have been full-term deliveries. Certainly, prematurity cannot be considered of any importance in the etiology of Mongolism.

Economic and Mental Status of Parents

The economic status of the children's parents is recorded in Table 9.

Table 9

Dependent	6
Marginal	88
Comfortable	103
Unknown	12

The intellectual status of the parents was estimated according to the information available in the anamneses with reference to education and other items. It was felt that of the entire group, only six parents could be classified as probably mentally defective, and two as probably of borderline intelligence. For the rest, it was estimated that the parents were of at least average intelligence and that 23 were possibly of superior intelligence.

Typical Characteristics of Mongolism

1. *Order of Birth.* Table 10 shows the distribution of the Mongol child in accordance with the familial order of birth.

Table 10

1st	57	7th	3
2nd	60	8th	1
3rd	47	13th	1
4th	26	Unknown	1
5th	8		
6th	5	Total	209

The groups of first, second or third children are not far from 25 per cent each. This is a result in keeping with the modern family of two or three children. However, no follow-up study has been made to determine the number of pregnancies subsequent to the admission of the Mongol child.

2. *Twins.* There were two cases of children who were twins, in the entire group. In both cases the twins were dizygotic; both were boy-and-girl pairs. The other member of the pair in each case was a normal child. This would give a ratio of 1:105 of twinning among these children, which is slightly less than the ratio usually given for twins in general, which is 1:87.

3. *Hand Lines.* The characteristic single line across the entire palm of the hand was found in 87 of 148 children examined.

4. *Small Finger of the Hand.* A deformed small finger of the hand was found in all cases. This finding has been confirmed by x-ray as a shortening of the middle phalanx. In some cases, the deformity is minimal. In the present series there were 21 cases where it was felt that there might be some doubt about deformity on external examination; however, the x-ray confirmed existence of the deformity.

5. *Rh.* One hundred seventeen children were tested for Rh with the following results: positive, 111 (94.9 per cent); negative, 6 (5.1 per cent).

Forty-one mothers were examined, and the following results were obtained: positive, 48 (92.7 per cent); negative, 3 (7.3 per cent).

In two of the cases both the mother and child were negative and in one case the mother was negative and the child positive.

6. *Size of Skull.* Circumference of the skull in Mongol children is smaller in practically all cases. Circumferences on admission are shown in Table 11.

Table 11

Inches less than average	Male	Female
Less than 1 inch	44	27
1-2 inches	60	36
2-3 inches	23	16
Greater than 3 inches	2	1
Total	129	80

The children were measured for the ratio of the lateral to the anterior-posterior diameter. The Mongol skull typically approaches a circle. The ratio of 1:1, however, was found in only one case. The skull ratio ranged from this down to .7187. The

mean was at .8275. The smallest lateral diameter was 11 cm., the largest 16 cm. The smallest posterior-anterior diameter was 13 cm., the largest 17 cm.

7. *Cardiac Disease.* Nineteen children were found to have some congenital cardiac defect. In most cases, this was a patent foramen ovale. This gives a percentage of 11.6 per cent with cardiac disease, and compares closely with the ratio of cardiac disease found in the autopsy material.

8. *Strabismus.* This is a common finding in Mongolism and was present in 36 of the children, or 23 per cent.

9. *Mental Status.* Children were divided according to the standard classification: idiot, imbecile, moron and borderline intelligence (Table 12).

Table 12

	Male Mongol	Female Mongol	Total Mongol	All admissions	Percentage type of all Mongols	Percentage type of all admissions
Idiot	12	7	19	210	9	26.9
Imbecile	76	46	122	445	58	57.1
Moron	40	26	66	118	32	15.1
Borderline	1	1	2	6	1	.8
Total	129	80	209	779	100	99.9

It will be noted that 58 per cent of the children fit into the imbecile grouping, 32 per cent into the moron grouping, or 90 per cent fit in the two classifications combined. The imbecile proportion is about equal to the proportion of admissions of imbeciles of all types into the school. The moron proportion is approximately twice the proportion of morons in the general admissions, whereas the idiot group is only a third that of the general admission rate.

10. *Discharges.* Sixteen of these Mongoloid patients were discharged from the school. Nine were in the school less than three months, for an average stay of 34 days. Five were in the school between two and six months, for an average of 113 days; and two were in the school more than six months, for an average of 276 days. The shortest period was nine days; and the longest period was 236 days, with a mean at 56.

11. *Deaths.* There were 45 deaths, a ratio of 21.5 per cent. Of these, 27, or 60 per cent, were autopsied. Of patients who died, 17

were in the school less than three months, for an average of 31.3 days; seven for a period of three to six months, with an average of four months, 19 days; 21 were in the school over six months with an average of one year, one month and 19 days. The shortest stay was 10 days; the longest two years, two months; the mean was at five months, 16 days.

Ages at death are shown in Table 13.

Table 13

Less than 1 year	9
1-2 years	15
2-3 years	14
3-4 years	5
4-5 years	1
5-6 years	1
Total	45

12. *Cause of Death.* The causes of death are shown in Table 14.

Table 14

Bronchopneumonia	33	
Lobar pneumonia	6	
Total of	39	or 86 2/3%
Congenital heart disease	5	11.1%
Nephritis	1	
*Myocarditis	1	
*Meningitis	1	

*The myocarditis and meningitis were concomitant in cases of bronchopneumonia.

Exposure of the Pituitary to X-ray Therapy

In conjunction with Ira I. Kaplan, M. D., of the Department of Radiation, Bellevue Hospital, a group of children suffering from Mongolism received x-ray therapy directed to the pituitary gland. This type of treatment was suggested by several factors. Clemens E. Benda in his book *Mongolism and Cretinism* states that the pathology of Mongolism indicates a congenital hypopituitarism. Dr. Kaplan reported that he had used similar therapy for 27 years in treating a number of married women, with excellent results in both restoring regular menstruation and increasing fertility.

The following program was laid down: Three ports of entry were used, the frontal and right and left temporal, 5 cm. in diameter. A dose of 100 r measured in air was given at each port at

each treatment at weekly intervals for four weeks. A second course repeated this procedure at the end of three months. During the second course, 50 r were administered and the area size was changed to 3 cm.

Each child was evaluated prior to, during, and after, treatment. The evaluation consisted of psychiatric examination, psychological evaluation and discussion with the ward personnel in care of each child. Although an occasional statement was made by the ward personnel that the child was talking better, had improved in toilet habits, dressing habits or eating habits, a careful survey showed that none of these improvements were unexpected in the natural course of growth in children of similar make-up. A report of the children treated is given in Table 15.

Table 15

Case No.	Date of birth	Admitted	IQ before treatment	IQ after treatment	Remarks
1. F. C.	10/18/46	11/20/48	31	29	Only change noted was development of a few words.
2. R. C.	7/2/46	2/25/49	32	29	Developed few words. Dressing with help.
3. R. C. No. 2	9/9/44	1/16/51	35	39	More active.
4. M. D.	11/20/45	11/23/48	18	20	No change.
5. M. E.	10/9/45	5/9/50	33	26	Developed few words. Learning to feed self.
6. A. D.	9/30/47	10/29/48	35	32	Trying to speak. No other change.
7. B. F.	11/12/45	11/19/50	26	23	No change.
8. C. G.	9/19/45	10/22/48	25	24	No change.
9. J. G.	9/7/45	8/4/49	23	25	No change.
10. I. H.	6/24/44	6/1/50	41	44	No longer enuretic. No other change.
11. H. L.	2/3/44	8/4/48	24	18	No change.
12. P. M.	6/23/47	5/4/50	36	34	No change.
13. D. S.	8/3/45	5/23/50	34	35	No change.
14. T. S.	2/3/45	9/13/51	51	42	Speaking more. No other change.
15. T. S. No. 2	1/16/47	3/2/49	11	33	No change.
16. A. T.	5/25/46	3/7/50	25	19	No change.
17. D. W.	10/4/44	9/28/50	32	32	No change.

Summary and Conclusions

1. An attempt has been made to discuss some of the more frequent circumstances concerning Mongolism.

2. Nothing was found to substantiate the claims that order of birth, age of parents, previous health of the mother, number of abortions, religion or economic status had any effect on the birth of Mongols.

3. The presence of the more typical signs of Mongolism is confirmed by examination of state school admissions.

4. The Rh factor does not appear to be of significance.

5. An attempt to stimulate the pituitary gland by means of x-ray radiation was unsuccessful. The Mongol brain is abnormal at birth, and it would seem improbable that treatment of the pituitary post-natally would cause any marked change in the complex pattern of the brain.

6. In the young age group of state school admissions studied, approximately 25 per cent were Mongols, constituting an important problem in the care and treatment of mental retardation.

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A METHOD OF RATING CERTAIN PERSONALITY FACTORS AS DETERMINED BY THE RORSCHACH TEST FOR USE IN A STUDY OF THE PRECURSORS OF HYPERTENSION AND CORONARY ARTERY DISEASE*

BY J. MARSHALL BRUCE, JR., AND CAROLINE BEDELL THOMAS, M. D.

Introduction

That patients with hypertension exhibit certain distinctive personality traits has been pointed out by a number of investigators in the rapidly growing field of psychosomatic medicine. A somewhat similar personality pattern has also been attributed to individuals suffering from coronary artery disease. Although such patients were studied *after* the appearance of clinical disease, the so-called "hypertensive" or "coronary" personality pattern was said in many instances to have existed from childhood. The difficulties of accurate description of the personality *before* the onset of disease by such retrospective methods, however, are readily apparent.

The "pre-hypertensive" and "pre-coronary" personality patterns are probably not identical with the patterns exhibited by patients already affected with one of these disorders, since alterations in personality are frequently occasioned by the presence of overt disease. Accordingly, precise delineation of the psychological characteristics of the "pre-hypertensive" or "pre-coronary" individual would require studying personality structures of apparently healthy young adults, with follow-up studies to ascertain which trait or combination of traits showed correlation with the subsequent development of disease. Using medical students as subjects, such a study has been undertaken as part of a broad investigation of the hereditary, physiological and psychological precursors of hypertension and coronary artery disease, two prevalent and serious disorders which in many ways are closely related and so have been considered together.

In approaching the difficult problem of determining significant differences in personality among subjects in the study, the Ror-

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schach examination has been one of the chief psychological instruments utilized because of its breadth and relative objectivity, and because it is sufficiently standardized to render it suitable for statistical analysis. Despite the large literature concerning the Rorschach test already at hand, it has been necessary to carry out certain basic studies on the writers' own material in order to make observations as precise and as suitable for comparison with other types of data as possible. The first need was to provide the proper orientation for the Rorschach phase of the program by comparing the subjects with other segments of the general population previously studied by the same technique. In a recent publication[1] the ranges of the various personality vectors of medical students as a group, as shown by the individual Rorschach test, were described and compared with those of other groups of normal subjects. The second need, namely to rate their component factors, becomes readily apparent in comparing and differentiating the Rorschach personality structures of a large number of individuals. Since the Rorschach records of many healthy young adults will contain some evidence of such common personality characteristics as anxiety, passivity or aggression, individual differentiation depends to a large extent upon the *degree* to which these factors are present in each record. In the present paper, a method of rating a number of personality traits as they appeared in the Rorschach records of the writers' subjects is presented, together with the precise definitions of the Rorschach determinants and the reasons for their selection.

Subjects

The rating of personality factors was performed on the Rorschach protocols of 85 Johns Hopkins medical students comprising nine first-year, 27 second-year, 10 third-year and 39 fourth-year students. They represent that part of the total group of medical students in the study whose Rorschach tests were administered and scored by one of the writers (J. M. B.). Of this group, 77 were men and eight were women. The mean age of the entire group of 85 was 24.8 years, with a range of from 21 to 32 years. Although no intelligence tests were performed upon this particular group, their present educational status bespeaks a generally superior degree of intelligence, and the finding of a mean

Wechsler-Bellevue full scale IQ of 131 among 47 unselected subjects in the study—as previously reported[1]—substantiates this view.

Procedure

All of the 85 records under consideration were administered, scored and interpreted in complete accordance with the principles and technique formulated by Beck,[2, 3] reference being made also to his later additions and changes in the scoring of F plus and F minus, changes in location charts and revisions of popular responses.[4] Further criteria for scoring responses as F plus or F minus were contained in a manual of collected responses prepared by Brown.[5]

Selection of Personality Factors

There have been a number of studies designed to ascertain which factors or clusters of factors delineate the hypertensive personality structure. Dunbar[6] associated with hypertension such personality characteristics as obsessive-compulsive trends, conflict between active-passive drives, anxiety, explosiveness, introversion, shyness and conventionality in social relationships, and neurotic symptoms. In discussing the personality in arterial hypertension Binger et al[7] also considered that obsessive-compulsive tendencies, anxiety and neurotic symptoms are of associative significance, and added such factors as suppressed hostility, submissiveness and dependence, feelings of weakness and helplessness, and tendency to depression. Using hypertensive individuals and two control groups, Gressel and his associates[8] studied the degree of association between the presence of hypertension and certain personality patterns and reported statistically significant degrees of association only for "obsessive-compulsive behavior" and "subnormal assertiveness." Alexander[9, 10] has made observations on the hypertensive personality structure, using the psychoanalytic technique. He reported that the patient's inability to express aggressive and self-assertive impulses stems from his emotional dependence on others, that his excessive aggressive-hostile impulses produce anxiety and guilt which he attempts to allay through compulsive behavior, and that a chronic state of inhibited aggressiveness produces a state of emotional tension which is one of the causal factors in his chronically elevated blood pressure. A number of others have contrib-

uted to the understanding of the hypertensive personality.[11-17] All the foregoing authors have based their findings on either the psychiatric interview or the psychoanalytic method. Thus far the Rorschach test has had very limited use in the study of hypertensive patients. Kemple[18] discussed the use of the test in the diagnosis of a number of psychosomatic diseases including hypertension. Without presenting her data specifically, she described personality vectors among hypertensive patients similar to those distinguished by Dunbar. Booth[19] was unable to establish any common statistical aspects among the individual Rorschach records of 60 hypertensive patients, using classical scoring categories. He, therefore, explored the possibility of finding other trends of form perception distinctive for hypertensive patients, and concluded that specific correlations among organ dominance, disease liability and form perception could be made using the Rorschach method.

The personality type of patients with coronary artery disease has long been recognized as that of the enterprising individual driving hard toward the top of his professional or business field. It remained for Dunbar,[6] however, to give more precise delineation to this personality profile. Individuals who suffer from a coronary occlusion resemble those with hypertension in some ways, she believes. They are, however, predominantly extratensive rather than introversive. The small percentage of them who show in addition a strong introversive tendency usually have some concomitant hypertension. The coronary patients have considerable evidence of control, presenting a surface calm, with little of the appearance of strain evident in hypertensive patients. Their typical life pattern of asceticism and hard work cloaks and rationalizes many compulsions. They rarely allow themselves freedom in emotional expression. In the paper mentioned previously, Kemple[18] substantiated most of these findings by the Rorschach technique, but suggested that coronary patients may display a good deal of emotion and hostility outwardly as well. Arlow,[20] in a psychiatric study of identification mechanisms in coronary occlusion, made subsidiary use of projective techniques and especially the Rorschach, but in his discussion did not differentiate the information gained from the Rorschach from that obtained through other methods. Thus, despite a few investigators[21-23] who have denied the presence of characteristic patterns for specific psychosomatic disorders, there has been considerable agreement among

many authors as to the personality traits which are generally found among hypertensive or coronary patients, even while individual differences are recognized.

Although in no way specific to the two diseases under investigation, 10 personality factors which appear to be most emphasized in the clinical literature just cited have been selected for primary study. The Rorschach determinants of each of these traits are obtainable. These 10 potential precursors of hypertensive or coronary personality patterns, which the authors have labelled "Primary Personality Factors," are as follows: obsessive-compulsive trends, passivity, aggression-hostility, anxiety, feelings of inadequacy (with reference to Binger's "feelings of weakness and helplessness"), depressive trends, impulsiveness (with reference to Dunbar's "explosiveness"), introversion, intellectual conformity (or social adaptivity, with reference to Dunbar's "conventionality in social relationships"), and neurotic trends. To take full advantage of the psychological data available in the Rorschach protocols, the writers have also included eight additional characteristics which they have labelled "Supplementary Personality Factors," some of which may prove to be of importance in the study: total affective reactivity, emotional rapport, fantasy activity, intellectual control, intellectual adaptivity, intellectual approach, intellectual drive and productivity.

Rorschach Determinants

Before discussing the writers' method of rating the personality factors thus selected, it is important to define clearly their Rorschach determinants. It is obvious that differentiating a group of Rorschach protocols according to the degrees to which their personality constituents are present necessitates very careful evaluation of just where and how these personality factors manifest themselves in the test. Since most of the writers' 10 "Primary Personality Factors" have several Rorschach determinants which in some cases are indirect and characterized by rather complex relationships, while the "Supplementary Personality Factors" have for the most part single, direct determinants, it is the former factors which require most specification here.

A. *Determinants of Primary Personality Factors*

1. *Obsessive-compulsive trends* are indicated structurally in an over-emphasis upon rare or minute details (Dd!) and in an ambi-

equal experience balance (sum movement = sum color responses). By over-emphasis upon rare or minute details, the writers refer to more than normal attendance to these areas as noted in the intellectual approach. Further but much less frequent evidence may be suggested by a preoccupation with symmetry, et cetera, or by a reluctance on the part of the subject to report a percept if the blot is not in complete structural conformity with it.

2. *Passivity* is indicated structurally in the specific shading determinant Y (used as achromatic color, shading and texture*), in a lack of resistance (space determinants) and in fantasy activity determined by flector movement. It is also manifest in passive, oral dependent trends in the associative content, especially in the content of fantasy activity. Determining passivity (as well as aggression-hostility) from the associative content presents a special problem, since the validity of some responses as indices of such personality characteristics is very difficult to ascertain. It should be noted that although a lack of aggression or resistance (S) may serve as an indirect index of passivity, the presence of the former in no way excludes that of the latter, these two factors frequently occurring concomitantly and in conflict in the same personality structure.

3. *Aggression-hostility* is listed here as a single factor with reference to the frequency with which "aggressive-hostile needs or impulses" are mentioned in the clinical literature on the hypertensive personality structure. However, holding to the theory that one can be aggressive without being hostile, the writers are treating this factor as a dichotomous concept by rating aggression and hostility separately. Although a psycho-philosophical-semantic analysis of the distinction between aggression and hostility is far beyond the scope of the discussion here, it is quite relevant to note that Beck[3, pp. 47-48] makes such a distinction when he considers that resistance, indicated structurally in the white space percept, implies perseverance, will power and determination in a strong and healthy personality structure but obstinacy, negativism and destructiveness in a weak and unhealthy one.

Thus, generally speaking, the white space determinants (S) are considered here to be one of the chief structural indices of healthy

*In a very recent revision of his *Basic Processes*, Beck (Ref. 4) differentiates shading and texture, scoring the latter "T" and considering it a determinant of "erotic needs" or "affect hunger."

aggression in a strong personality, and of hostility or negativism in a weak, unhealthy one. Another structural indication of aggression is manifest in fantasy activity determined by extensor movement. Both aggressive and hostile trends can be observed in the associative content, especially in the content of fantasy activity.

Finally, for those who disagree with the thesis that while hostility would seem to imply aggression the converse does not necessarily follow, aggression-hostility can still be considered here as a single factor or concept and rated as such.

4. *Anxiety* in the Rorschach has a multitude of determinants, both direct and indirect, which are frequently characterized by rather complex relationships. Thus one can only outline here the principal ways in which it manifests itself.

The writers have delineated two types of anxiety—a basic or deep-seated type which stems from a central character force and a more superficial type frequently incurred under the influence of exciting environmental stimuli. The former type of anxiety is indicated primarily in shading shock, while the latter type is manifest in neurotic or color shock. As determinants of each of these types of shock the writers have used the numerous indices discussed by Beck.[3, pp. 37-41]

Another general manifestation of anxiety can be observed in the debilitation of personality functioning through the constriction of psychic energies, with reference to such factors as paucities of productivity (R), intellectual drive (Z), fantasy (M) and affect (C), as well as rigidity of intellectual control (F+%), emotional control (FC) and intellectual adaptivity (A%).

Further indices of anxiety can be noted in generally delayed reaction times, prevalence of human detail over whole human percepts (Hd>H), the specific indicator (X), over-emphasis upon minute details (Dd!), and the disquieting affect or dysphoric mood implicit in shading (Y) and vista (V) determinants.[3, pp. 33-36] Finally, in view of the inclination of medical students to give anatomical associations, the writers have given little consideration to anatomy responses as determinants of anxiety.

5. *Feelings of inadequacy* or inferiority-consciousness are implicit in the self-evaluation which is structurally indicated in vista determinants (V). Further evidence of such a trend occurs less frequently in the associative content.

6. *Depressive trends* represent the most ambiguous and potentially least meaningful factor selected for study, for the writers are using the term "depressive" here both subjectively to designate a mood or feeling tone and objectively to indicate an inhibiting agent. The Rorschach determinants of such trends are approximately the same as those of anxiety. Thus, a dysphoric mood or disquieting and oppressive affect is manifest in shading shock and in shading and vista determinants (Y,V) while the inhibition of personality functioning can be noted in constriction of the various psychic energies (see discussion of *Anxiety*). Depressed feelings are observed at times in the associative content, especially in the content of fantasy activity.

7. *Impulsiveness* or trends to impulsivity are implicit in the labile affectivity which is structurally manifest in responses determined entirely or primarily by color (C, CF). Further but less frequent evidence of a trend to impulsivity or emotional instability can be obtained from considerably increased productivity under the emotional stimulus or excitement of colored cards VIII to X where, roughly, the ratio of productivity in these cards to that in all the others is higher than .85.[3, p. 32]

8. *Introversion** is indicated in the experience balance where the total number of movement responses is significantly greater than the sum of color responses (total number M>sum C).

9. *Intellectual conformity* or conformity to the thinking of others, which Beck[3, p. 17] also interprets as social adaptivity, is indicated in the popular responses (P).

10. *Neurotic trends,* being a rather nebulous term and having a multiplicity of Rorschach indices, may prove to be one of the less meaningful factors selected for study. However, the writers have considered their determinants to be represented in two principal categories: neurotic or color shock, the various indices of which are enumerated by Beck,[3, pp. 37-41] and the presence, excess or constellation of factors commonly associated with neurotic personality structures.

**Extratension* has not been listed as a separate factor, as its presence is in inverse proportion to that of introversion. Thus extratension is present when sum C is significantly greater than the total number of M responses, and the experience balance is ambiequal when sum C and the number of M responses are equal or approximately so.

B. *Determinants of Supplementary Personality Factors*

1. *Total affective reactivity* or the total amount of affect released is the first one of the writers' "supplementary personality factors" and is indicated in the sum of color responses (sum C).

2. *Emotional rapport,* in some ways antithetical to "impulsiveness," is indicated in those responses in which form is the primary and color the secondary determinant (FC).

3. *Fantasy activity* or inner living is indicated in movement responses (M).

4. *Intellectual control,* ego strength or regard for reality is indicated in the percentage of responses determined by good form (F+%).

5. *Intellectual adaptivity,* from originality to stereotypy of thinking, is indicated in the percentage of animal responses (A%).

6. *Intellectual approach* is indicated in the distribution of whole (W), common or major detail (D) and rare or minute detail (Dd) responses implying respectively capacities for abstraction, practicality and detail.

7. *Intellectual drive* is indicated in organizational activity (Z).

8. *Productivity* is indicated in the total number of responses to the test (R).

Rating

An attempt to rate or determine the degree to which various personality factors are present in a given Rorschach record obviously raises many problems, some of which are general and others of which are specific to the particular factor being rated. Some of the general difficulties encountered will be mentioned here, and the more specific problems will be dealt with as the method of rating each personality factor is discussed.

Perhaps the first and most basic question which should be raised concerns the rationality of attaching so much importance to the absolute value of a specific Rorschach personality factor when it has been taken out of context and isolated from the particular personality structure of which it is a dynamic part. Thus, marked degrees of aggression, passivity or self-evaluation, for example, may have unhealthy or neurotic implications in one personality structure but not in another. Again, since rating must acknowledge the presence of a factor, no matter how moderate its degree, some distortion of perspective is likely. Thus, while the usual

Rorschach interpretation would hardly attach much significance to or make mention of the aggression, passivity or inferiority-consciousness implicit respectively in a single white space, single shading or single vista determinant, the writers' approach in rating must distinguish between the modest occurrence and complete absence of such factors and mention their presence under such circumstances as "little."

Another major problem is represented in the extreme difficulty of rating such personality factors as anxiety and neurotic trends, the Rorschach determinants of which are so numerous and diversely interrelated, or such factors as aggression and passivity, elements of which are frequently manifest in the associative content. As it is extremely difficult to establish precisely objective criteria for measuring such complex factors, rating must be to a large extent subjective. To facilitate handling the problem of validity inherent in any subjective rating and to expedite any rerating which may be required, the writers have supported each such measurement in each Rorschach protocol by recording in detail all the determinants of each specific rating.

The factor of productivity raises a problem in rating even those personality characteristics which have single Rorschach determinants and for which objective criteria can be established. Thus, should one measure intellectual drive (Z), resistance (S), self-evaluation (V), fantasy (M) or affect (C) in a Rorschach protocol with reference to their absolute amount or relative amount, productivity (R) being the determining variable in the latter case? A subject whose high productivity contains only an average number of movement responses still shows a normal amount of fantasy activity even if the relative amount of movement responses is low. Another subject whose low productivity contains an average number of movement responses also shows only a normal amount of fantasy activity even though the relative amount of movement responses is high. Whether or not average productivity from this latter subject would have contained a superior number of movement responses indicating a marked amount of fantasy activity may well be an academic question here and is one which was not considered in this study. Thus, since the dynamic relationship between productivity and other Rorschach personality factors is by no means precisely ascertainable, the writers have, generally speaking, rated such factors as fantasy or affect with reference to their

absolute amount, qualifying all instances in which discrepant productivity would seem to be significant and using productivity itself as a determining variable only in exceptional cases where such discrepancy is great and is supported by other determinants.

A fourth major problem is specific to the superior intelligence of the writers' subjects and the nature of this study. Should one rate the personality factors in these Rorschach protocols generally with reference to standards for persons of superior intelligence? At the present time, the norms which have been derived for superior groups are by no means well established and are often contradictory. Thus the writers have rated all their Rorschach personality factors with reference to norms for the general population, qualifying, however, and also interpreting with reference to norms for superior individuals, such factors as productivity, intellectual drive, fantasy or intellectual adaptivity, which seem most likely to be affected by the factor of intelligence.

With the exception of introversion and intellectual approach, the writers have rated the selected Rorschach personality factors with reference to five different degrees or amounts and, equating "moderate" with "average," have used the following scale, employing in each case that term which best describes the particular factor being rated: (1) not apparent; very low; (2) little; low; (3) moderate; average; (4) marked; high; and (5) very marked; very high.

The basic criteria which have played a part in the present rating, that is to say, the various norms and means upon which the standards have been based, are represented in the approximate levels for a number of Rorschach determinants and the means for two different control groups of normal subjects all established by Beck[24, 3 (pp. 12-20), 25]—as well as in the means for a group of superior subjects (medical students) derived by Molish.[1] As such criteria are frequently at variance, the writers' standards for distinguishing between five different degrees or levels are to some extent arbitrary. Nevertheless, they provide a uniform basis for differentiation, which is the important consideration.

A. *Primary Personality Factors*

1. *Obsessive-compulsive trends* have been rated as "little" when the emphasis on rare or minute details is quite modest (Dd!) and/or a dilated experience balance approaches ambi-equality (M/C=10/11), as "moderate" when the emphasis on rare or

minute details is well delineated (Dd!) and/or the experience balance is ambi-equal or approximately ambi-equal (M/C=4/4 or 4/3.5), as "marked" when the number of rare or minute detail responses is twice the normal expectancy (Dd!!) and as "very marked" when this number is three times the normal expectancy (Dd!!!), allowance being made in these last two cases when unusually low productivity invalidates the use of a proportion as a determinant for rating. Obsessive-compulsive trends may also be rated from "little" to "very marked" depending upon the degree to which such relatively infrequent phenomena as preoccupation with symmetry or perfection of form are present, a degree which must be subjectively determined.

2. *Passivity,* generally speaking, has been rated as "little" when shading responses (FY) number one or two, as "moderate" when such responses number three or four, as "marked" when they number five through eight and as "very marked" when they number nine or more. Such a procedure can serve at best only as an approximate basis for rating, allowance being made for the degree to which shading determines such responses (FY, YF or Y), the size or massiveness of the shaded areas selected, the intensity or depth of the dark areas used, and in exceptional cases the relative amount of productivity. Although the writers' rating has taken into consideration such factors as the size and darkness of these shaded areas, most emphasis has been placed upon the total number of shading responses and the degree to which shading determined them.

Passivity manifest in flector movement responses and in the associative content has been rated subjectively with reference to the number, strength and clarity of such responses, special emphasis having been placed upon inactive, passive, oral and dependent trends in the content of fantasy activity.

Since passivity and aggression are by no means mutually exclusive and conflict between such trends is contained in many personality structures, the presence of one does not alter the rating of the other except in rare instances where a complete lack of resistance (total space determinants =0) would change "little" passivity (FY=1 or 2) to "moderate" passivity, absence of resistance (S=0) in itself never indicating more than "moderate" passivity. Thus, "marked" passivity (FY=8) is still rated as such when accompanied by "marked" aggression (S=8), and vice versa.

3. *Aggression-hostility* has been treated dichotomously in accordance with the writers' thesis that while hostility implies aggression the converse does not necessarily follow. In general, they have considered resistance (S) determined structurally by white space responses as synonymous with aggression in a healthy or strong personality where the release of space responses is not markedly greater than the general liberation of other psychic energies. Thus, under such conditions a single space response has been rated as "little" aggression, two to four space responses as "moderate" aggression, five through 10 such responses as "marked" aggression and 11 or more as "very marked" aggression, again taking into consideration the size of the white space areas selected, whether or not such an area was selected alone or in combination with another part of the blot, and, in exceptional cases, the relative productivity. The writers have considered resistance (S) to have negativistic or hostile implications in an unhealthy or weak personality or in any personality structure where the release of space responses is markedly greater than the general liberation of other psychic energies. Under such conditions hostility must be rated subjectively with reference to the degree of morbidity manifest in a particular personality structure and the number of space determinants employed, or with reference to the degree to which space determinants predominate over the Rorschach determinants of other psychic energies.

Aggression indicated in extensor movement responses, as well as both aggression and hostility manifest in the associative content, have been rated subjectively with reference to the number, strength and clarity of such responses, special emphasis having been placed upon aggressive or hostile trends in the content of fantasy activity.

In rating aggression and hostility separately, it would seem expedient to specify that the amount of hostility will never exceed that of aggression, although aggression may often predominate over hostility. Finally, for those who reject the writers' thesis that aggression does not necessarily imply hostility and who consider hostility and aggression as a single psychological concept, aggression-hostility also may be and has been treated as a single factor by assigning to it the rating for aggression effected under the system of dichotomous measurement used.

4. *Anxiety* has proved to be the most difficult factor to rate because of the multitude and complexity of its Rorschach determinants. Since it is practically impossible to establish objective criteria for measuring any of its determinants, rating must be based upon a subjective evaluation of the total picture. Shading shock, color shock and constriction are in themselves rather complex and are characterized by numerous determinants. To evaluate shading or color shock, necessitates ascertaining the frequency and severity of delayed reaction times, reduced productivity, breakdown of intellectual control and so on, while determining the degree of constriction involves an appraisal of such factors as productivity, intellectual drive, intellectual adaptivity, intellectual control, fantasy and affect. Thus, after an evaluation has been made of shading and color shock, of constriction, and of such miscellaneous phenomena as the specific-indicator X, prevalence of human detail over whole human percepts, emphasis on rare or minute details, passivity (Y) and inferiority consciousness (V), a subjective rating of from "little" to "very marked" anxiety is effected.

As already stated in the discussion of Rorschach determinants, the writers have regarded shading shock as implying the presence of a basic or deep-seated type of anxiety which stems from a central character force, while they have interpreted neurotic or color shock as evidence of the more superficial type of anxiety incurred under emotionally exciting environmental stimuli. Since both of these phenomena have contributed to a single, final rating for anxiety, the problem arises as to whether or not they should be given equal emphasis. Although the situational anxiety indicated in color shock can be both strong and incapacitating, the basic anxiety manifest in shading shock would seem to have more chronic and pathological implications. Consequently, this latter type of anxiety has, generally speaking, merited the primary consideration.

5. *Feelings of inadequacy* (inferiority-consciousness, self-evaluation) have been rated primarily with reference to the number and strength of vista determinants. The writers have, generally speaking, rated such trends as "little" when a single vista response of modest strength (reflection in water, etc.) or several weak and questionable vista responses (unelaborated map percepts of land and water, etc.) are given, as "moderate" when two to four vista responses of modest strength or one to two strong vista responses

(mountains or skyline in the distance, etc.) are given, and as "marked" or "very marked" when more than four vista responses of at least modest strength or more than two strong vista responses are given, the distinction between these last two levels of rating not being sufficiently delineated to be recorded. In exceptional instances allowance has been made for relative productivity. Finally, inadequacy or inferiority feelings indicated at times in the associative content must be rated subjectively.

6. *Depressive trends,* like anxiety, have necessitated a subjective rating of the total picture after an evaluation has been effected of such complex phenomena as shading shock, shading and vista determinants, and constriction. Depressive trends in the associative content must also be rated subjectively.

7. *Impulsiveness* or trends to impulsivity have been rated with reference to the amount of unstable or labile affectivity (C, CF) relative to the amount of emotional adaptivity and control (FC) in accordance with the writers' thesis that the general nature or final pattern of one's affective reactivity to life situations will be determined by the interaction of these psychic forces. Generally speaking, the writers have considered an average ratio or distribution of color responses (F=1, CF=2, FC=3) as representing a normal amount of emotional lability or moderate tendency to impulsivity and have rated trends from "little" to "very marked" in accordance with the degree to which a given distribution of color responses deviates from this basic or normal ratio respectively in the direction of controlled or labile affect.

Since there are so many different distributions of color responses, and no basic ratio or normal expectancy can by any means be rigidly adhered to, one can record here only several distributions under which the different levels of rating were achieved. Thus, generally speaking, where the amount of labile affect is less than the normal expectancy (*C*=0, *CF*=1, FC=3) or where the amount of controlled affect is above the normal expectancy (C=1, CF=2, *FC*=7) the writers have rated trends to impulsivity as "little"; where the amount of both labile and controlled affect conforms to or approximates the normal distribution or expectancy (C=1, CF=2, FC=3; or C=1, CF=1, FC=2) they have rated such trends as "moderate"; where the amount of labile affect is significantly greater than the normal expectancy (*C*=2, *CF*=6, FC=3) or where the amount of controlled affect is significantly

below the normal expectancy (C=1, CF=2, *FC*=1) they have rated such trends as "marked"; where the amount of labile affect is markedly greater than the normal expectancy (*C*=5, *CF*=8, FC=3) and where, in any distribution, labile affect greatly outweighs controlled affect or there is extreme emphasis upon primitive affectivity (pure C) they have rated such trends as "very marked." At the same time, they have, of course, given consideration in their rating to those color responses determined by poor form, making the necessary allowance for unsuccessful attempts at emotional control (FC—) and differentiating CF+ and CF— responses as to the degree of lability contained therein.

Finally, trends to impulsivity determined at times by increased productivity under the emotional stimulus of color must be rated subjectively.

8. *Introversion* has been rated with reference to the criteria formulated by Beck[25] and followed by Molish et al.[1] Thus, introversion has been considered "moderate" when the number of movement responses is one to two greater than the sum of color responses, as "marked" when the number of movement responses is three to five greater than the sum of color responses and as "very marked" when the number of movement responses is six or more greater than the sum of color responses. Inversely, this same quantitative relationship between movement and color responses has been used to determine the degree of extratension, implying ambivalence when the number of movement responses and sum of color responses are equal or approximately equal.

9. *Intellectual conformity* or social adaptivity has been rated "very low" when the number of popular responses (P) is one or two, "low" when such responses number three to five, "average" when they number six to nine, "high" when they number 10 to 12 and as "very high" when they number 13 or more. Since the normal range of intellectual conformity is rather wide, the writers have distinguished between a "low-average" level indicated in six popular responses and a "high-average" level manifest in nine. At the same time, they have regarded the high intellectual conformity implicit in 10 or more popular responses as suggestive of various degrees of overconventionality. Finally, intellectual conformity has been rated with reference to the absolute number of popular responses, not utilizing relative productivity as a determining variable since such responses would seem to be basic or primary and

theoretically among the first to be given in a record characterized by either low or high productivity.

10. *Neurotic trends,* like anxiety, are sufficiently complex to necessitate a subjective rating of the total picture after an evaluation has been made of such multi-determined phenomena as neurotic or color shock, constriction of psychic energies, and general morbidity of personality characteristics. By morbidity of personality characteristics is meant pathological implications of marked anxiety, passivity, aggression-hostility, inferiority-consciousness, obsessive-compulsive and depressive trends and so on, and, especially, instances where marked degrees of such factors occur in combinations or clusters pathognomonic of neurotic personality structures.

B. *Supplementary Personality Factors*

1. *Total affective reactivity,* the first one of the supplementary personality factors, has been rated as *"little"* when the sum of color responses is 1 or 2, as "moderate" when sum C is 3 or 4, as "marked" when sum C is 5 to 7 and as "very marked" when sum C is 8 or more. In exceptional instances, where discrepancy between the total amount of affectivity and productivity (R) is great, the rating has been qualified accordingly.

2. *Emotional rapport* has been rated according to the amount of controlled (FC) relative to the amount of labile (C, CF) affectivity, the average ratio or distribution of color responses (C=1, CF=2, FC=3) representing a normal or moderate degree of affective rapport. Thus emotional rapport has been rated from "little" to "very marked" in accordance with the degree to which a given distribution of color responses deviates from this basic or normal ratio in the direction of labile or controlled affect respectively.

3. *Fantasy activity* or inner living has been rated as "little" when there is only one movement response, as "moderate" when M numbers two to four, as "marked" when M numbers five to eight and as "very marked" when M numbers nine or more. At the same time such ratings have been qualified, and the amount of fantasy activity has been interpreted with reference to the mean for persons of superior intelligence (M=7), special emphasis being placed upon those cases in which inner living is significantly under the average. Where discrepancy between the amount of fantasy activity and productivity is great, the ratings have also been qualified accordingly.

4. *Intellectual control* (ego strength, regard for reality) has been rated as "very low" when the percentage of good form (F+) is below 55, as "low" when F+% is 55 to 64, as "average" when F+% is 65 to 84, as "high" when F+% is 85 to 94 and as "very high" when F+% is 95 to 100. Since the normal range of intellectual control is rather wide, the writers have further differentiated between "low-average" (F+%=65 to 69) and "high-average" (F+%=80 to 84) levels. At the same time, intellectual control has been interpreted as representing various degrees of rigidity when F+% is around 90 or above. Where intellectual control is significantly under the average for persons of superior intelligence (mean F+%=86), the ratings have been qualified accordingly.

5. *Intellectual adaptivity* has been rated as "very low" when the percentage of animal responses is below 25, as "low" when A% is 25 to 34, as "average" when A% is 35 to 54, as "high" when A% is 55 to 60 and as "very high" when A% is 61 or above. Since the normal range of intellectual adaptivity is rather wide, the authors have further indicated a "low average" (A%=35 to 39) and a "high average" (A%= 50 to 54) level. At the same time, they have regarded intellectual adaptivity as representing a continuum from originality to stereotypy of thinking, various degrees of which have been especially established where the ratings have been qualified and intellectual adaptivity has been interpreted with reference to the mean for persons of superior intelligence (A%=37). Thus an A% of 27 would be interpreted as representing low intellectual adaptivity but high originality of thinking for a person of superior intelligence; an A% of 36 as representing a low average level of intellectual adaptivity but average originality of thinking for a person of superior intelligence; an A% of 46 as representing a general average level of intellectual adaptivity but as rather high and indicative of some stereotypy of thinking for a person of superior intelligence and an A% of 58 as representing high intellectual adaptivity, especially high and indicative of extreme stereotypy of thinking for a person of superior intelligence.

6. *Intellectual approach* has been rated as moderately abstract (W) when emphasis upon whole responses is rather modest, as abstract (W!) when emphasis upon such responses is well delineated, as markedly abstract (W!!) when such responses number twice the normal expectancy and as very markedly abstract (W!!!)

when they number three times the normal expectancy. In like manner, the approach has been rated as practical (D) or detailed (Dd) according to the degree of emphasis upon major or rare detail responses respectively, except where it is markedly or very markedly practical (D!! or D!!!) and cannot be rated with reference to a ratio because of the relatively high number of major detail responses in a normal distribution. Such ratings have also included a consideration of the degree to which these emphasized responses occur at the expense of other types of responses. Thus the intellectual approach implicit in a given distribution (W=14, D=12, Dd=4) would be rated as markedly abstract (W!!) at the considerable expense of the practical (D) and with normal attention to the detailed (Dd). Intellectual approach has been rated as "normal" when these three types of responses assume or approximate the normal distribution (W=6, D=20, Dd=4).

7. *Intellectual drive* has been rated as "very low" when organizational activity (Z) is below 20, as "low" when Z is 20 to 25, as "average" when Z is 26 to 40, as "high" when Z is 41 to 55 and as "very high" when Z is 56 or above. The writers have further distinguished between "low-average" (Z=26 to 29) and "high-average" (Z=37 to 40) levels. At the same time, such ratings have been qualified and the amount of intellectual drive has been interpreted with reference to the mean for persons of superior intelligence (Z=53), special emphasis being placed upon those cases in which organizational activity is significantly under the average. Where discrepancy between the amount of intellectual drive and productivity is great, the ratings have also been qualified accordingly.

8. *Productivity* has been rated "very low" when the number of responses (R) is below 20, "low" when R is 20 to 29, "average" when R is 30 to 44, as "high" when R is 45 to 59 and as "very high" when R is 60 or above. The writers have further differentiated "low-average" (R=30 to 34) and "high-average" (R=40 to 44) levels. Finally, such ratings have been qualified and the amount of productivity has been interpreted with reference to the mean for persons of superior intelligence (R=55), special emphasis being placed upon those cases in which productivity is significantly under the average.

Results

The results of the rating of the 85 Rorschach protocols are set forth in Tables 1, 2, 3. It must be emphasized that each term used in the tables is implicitly modified by the phrase "as revealed by the Rorschach determinants according to the definitions presented," and does not necessarily correspond to the impression made by the subject in everyday living. While detailed comment on each trait is unnecessary, certain features are worthy of note.

It may be pointed out that the distribution curves resulting from this method of rating vary considerably from trait to trait. In many of the traits, application of these criteria disperses the subjects over a wide spectrum, with sufficient numbers of individuals at different points of the curve to provide a satisfactory basis for comparison. Traits exhibiting a simple distribution curve with a satisfactory range include fantasy activity and intellectual drive. Other traits, such as obsessive-compulsive trends and feelings of inadequacy, show a bimodal type of curve, suggesting two rather different types of response to the test situation. As a result, one

Table 1. The Occurrence of 10 "Primary Personality Factors" as Determined from the Rorschach Tests of 85 Medical Students*

Personality factor	Not apparent Very low		Little Low		Moderate Average		Marked High		Very marked Very high	
	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent
Obsessive-compulsive trends	51	60.0	8	9.4	19	22.4	4	4.7	3	3.5
Passivity	0	0.0	10	11.8	37	43.5	26	30.6	12	14.1
Aggression-hostility	3	3.5	14	16.5	40	47.1	22	25.9	6	7.1
Aggression	3	3.5	14	16.5	40	47.1	22	25.9	6	7.1
Hostility	14	16.5	31	36.5	29	34.1	9	10.6	2	2.4
Anxiety	0	0.0	3	3.5	39	45.9	42	49.4	1	1.2
Feelings of inadequacy	26	30.6	8	9.4	36	42.4	11	12.9	4	4.7
Depressive trends	0	0.0	16	18.8	54	63.5	15	17.7	0	0.0
Impulsiveness	10	11.8	7	8.2	32	37.7	32	37.7	4	4.7
Introversion	51	60.0	..	..	13	15.3	15	17.7	6	7.1
(Extratension)	(6)	(7.1)	(15)	(17.7)	(13)	(15.3)	(..)	(..)	(51)	(60.0)
Intellectual conformity	3	3.5	18	21.2	50	58.8	14	16.5	0	0.0
Neurotic trends	1	1.2	7	8.2	36	42.4	40	47.1	1	1.2

*Apply rating terms in first row across top to all factors except intellectual conformity in which case apply terms in second row.

Table 2. The Rating of Eight "Supplementary Personality Factors" Based on the Rorschach Tests of 85 Medical Students*

Personality factor	Not apparent Very low No.	Per cent	Little Low No.	Per cent	Moderate Average No.	Per cent	Marked High No.	Per cent	Very marked Very high No.	Per cent
Total affective reactivity	4	4.7	23	27.1	17	20.0	25	29.4	16	18.8
Emotional rapport	22	25.9	24	28.2	34	40.0	3	3.5	2	2.4
Fantasy activity	5	5.9	8	9.4	27	31.8	30	35.3	15	17.7
Intellectual control**	0	0.0	19	22.6	51	60.7	12	14.3	2	2.4
Intellectual adaptivity	8	9.4	13	15.3	58	68.2	2	2.4	4	4.7
Intellectual drive	7	8.2	9	10.6	31	36.5	20	23.5	18	21.2
Productivity	4	4.7	15	17.7	32	37.7	16	18.8	18	21.2

*Apply rating terms in first row across top to first three factors and the terms in second row to last four factors.

**F+% not obtainable in one record where there were no responses determined by form alone.

Table 3. Intellectual Approach

	Moderate	Well-delineated	Marked	Very marked	Total
Normal (W-D-Dd)	..	..	..	..	3
Abstract (W!)	7	6	9	2	24
Practical (D!)	33	13	2	0	48
Detailed (Dd!)	8	9	4	3	24

might, with considerable confidence, compare the 26 subjects with "moderate" to "very marked" obsessive-compulsive trends, on the one hand, with the 59 subjects who showed little or no tendency in that direction on the other. Based as it is upon measurable Rorschach determinants, the prominence or lack of prominence of this trait provides a consistent way of separating unselected subjects into two categories. In the case of a few traits, however—particularly anxiety, depressive trends and neurotic trends—the subjects were not well distributed over the full range of the arbitrary scale. It would appear, therefore, that the present criteria for the latter traits are unsuitable for purposes of differentiation, at least among such a relatively homogeneous group as medical students.

At present, the validity of this method of rating cannot be directly determined. Time alone will tell whether significant differences in personality structure are thus delineated and whether individuals destined to develop hypertension or coronary artery dis-

ease may be distinguished from those who are not by means of such differences. Two indirect forms of observation bear on the general problem, however. First, the writers have compared the Rorschach protocols of the 25 subjects giving a definite history of parental hypertension and/or coronary artery disease with the protocols of the 26 students whose parents were free from both these disorders.*

Although hypertension and coronary artery disease will probably appear among the subjects of both groups in the years to come, the proportion of affected subjects may be expected to be significantly larger among those with a known heritage of cardiovascular disease.[26] Accordingly, traits closely associated with the hypertensive and/or coronary personality structure should be more prominent among subjects with parental hypertension and/or coronary disease than among subjects *without* such parental history. A comparison of the degree to which the personality factors considered in this paper appear in these two groups of subjects is shown in Table 4. For purposes of simplification, all those showing more than a "moderate" or "average" degree of a given trait are grouped together under the term "abundant," while all with less than a "moderate" or "average" amount are grouped under the term "meager."

It will be seen that the majority of the traits appear to be present to about the same extent in each group, regardless of parental history. Aggression-hostility, obsessive-compulsive trends, and feelings of inadequacy, however, are more prominent among subjects with a positive parental history. (Table 4, Figure 1). Conversely, those with healthy parents react with more impulsiveness and total affective reactivity than do those with parental hypertension and/or coronary artery disease. Although the number of subjects involved is small, these differences approach statistical significance.

The fact that some of the Rorschach protocols are highly suggestive of the "hypertensive" or "coronary" personality structure described in the literature is also an indirect point of importance. Personality profiles of the "hypertensive" or "coronary" type were

*The parents of the negative group were also free from obesity and diabetes, disorders which often precede cardiovascular disease. The remaining 34 subjects could not be assigned to either group for the following reasons: parental history incomplete, questionable for hypertension or coronary disease, or positive for obesity.

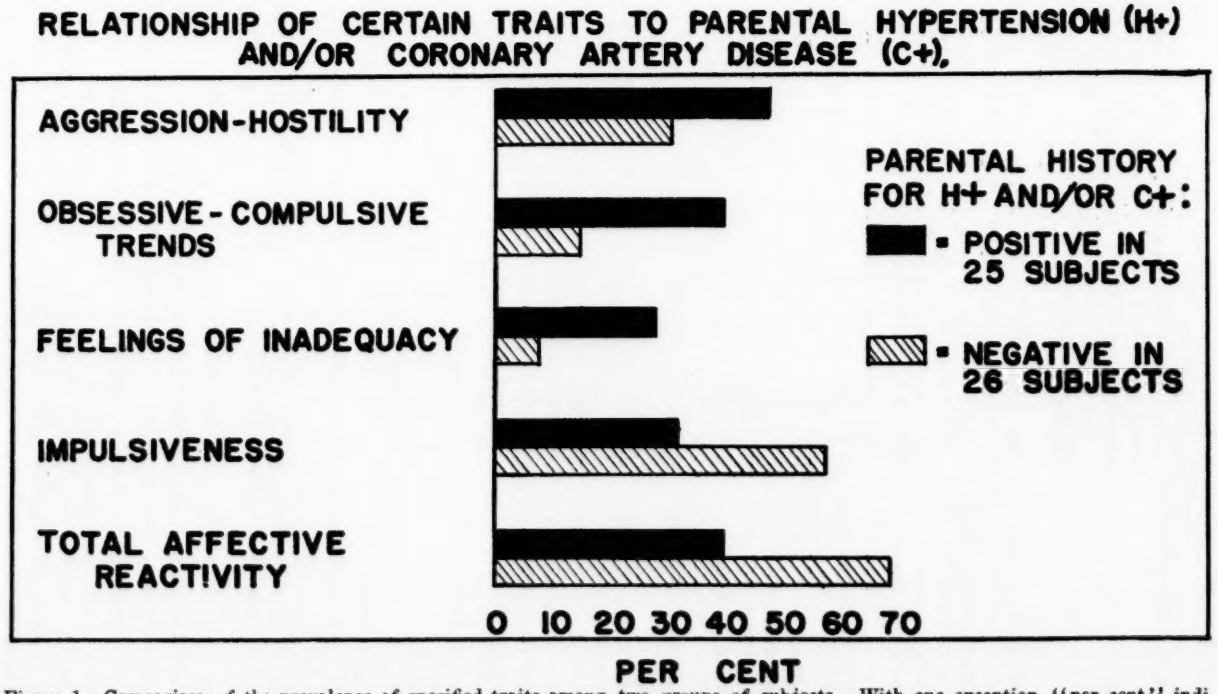

Figure 1. Comparison of the prevalence of specified traits among two groups of subjects. With one exception, "per cent" indicates those showing a given trait in abundance (as defined in the text and as in Table 4). In the case of obsessive-compulsive trends, however, those showing a *moderate* degree of the trait and those having it to a *marked* or *very marked* degree were combined, because of the bimodal distribution curve of this trait.

Table 4. A Comparison of the Occurrence of Certain Personality Factors Among Subjects with and without Parental Hypertension (H+) and/or Coronary Artery Disease (C+)

Evidence for presence of factor	Among 25 subjects with parental history positive for H and/or C				Among 26 subjects with both parents negative for H, C, O* and D**			
	Abundant†		Meager‡		Abundant		Meager	
	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent
A. Primary personality factors								
1. Obsessive-compulsive trends	4	16.0	15	60.0	1	3.8	22	84.6
2. Passivity	11	44.0	5	20.0	14	53.8	2	7.7
3. Aggression-hostility	12	48.0	6	24.0	8	30.8	6	23.1
4. Anxiety	14	56.0	2	8.0	12	46.2	1	3.8
5. Feelings of inadequacy	7	28.0	9	36.0	2	7.7	13	50.0
6. Depressive trends	6	24.0	4	16.0	4	15.4	3	11.5
7. Impulsiveness	8	32.0	7	28.0	15	57.7	4	15.4
8. Introversion	6	24.0	16	64.0	7	26.9	16	61.5
(Extratension)	(16)	(64.0)	(6)	(24.0)	(16)	(61.5)	(7)	(26.9)
9. Intellectual conformity	4	16.0	10	40.0	5	19.2	3	11.5
10. Neurotic trends	16	64.0	3	12.0	11	42.3	4	15.4
B. Supplementary personality factors								
1. Total affective reactivity	10	40.0	8	32.0	18	69.2	7	26.9
2. Emotional rapport	2	8.0	13	52.0	1	3.8	15	57.7
3. Fantasy activity	14	56.0	7	28.0	17	65.4	2	7.7
4. Intellectual control	5	20.0	6	24.0	4	15.4	7	26.9
5. Intellectual adaptivity	1	4.0	5	20.0	2	7.7	9	34.6
6. Intellectual drive	12	48.0	5	20.0	15	57.7	4	15.4
7. Productivity	11	44.0	6	24.0	10	38.5	4	15.4

*O=Obesity.

**D=Diabetes.

†"Abundant" includes categories "marked or high" and "very marked or very high" in Tables 1 and 2.

‡"Meager" includes categories "Little or low" and "not apparent or very low" in Tables 1 and 2.

somewhat more frequent among subjects with a positive parental history. Examples of such protocols are as follows:

Subject 52M65

This subject's father had hypertension, died of a stroke.

1. *Obsessive-compulsive trends*—very marked—very strong concentration upon minute details (Dd!!!) supported by an approximately ambiequal experience balance (Exp=6/5.5).

2. *Passivity*—marked—indicated structurally by considerable concentration on shading determinants (FY=4, CF*Y*= 1, MF*Y*=1, C.*Y*.V=1) and supported by a decidedly weak and passive trend throughout fantasy activity (M=6).

3. *Aggression-hostility*—marked—considerable resistance in use of white space (S=5) supported by hostile elements throughout content ("blood stains, drops of blood, angry bulls, clenched fists, gashes from mouths to chins").

4. *Anxiety*—marked indication—as noted in emphasis on shading elements (sum Y=7, sum V=4), suggestion of shading shock on card VII (extreme breakdown of intellectual control and use of autistic fantasy), prevalence of human detail over whole human percepts (Hd=8, H=2), specific anxiety indicator (Hdx=1), and extent to which S escapes into preoccupation with minute details (Dd!!!)—especially in the anxiety-producing shaded cards.

5. *Depressive trends*—moderate—as suggested in dysphoric affect (sum Y=7, C.Y.*V*.=1, FV=3—see following).

6. *Feelings of inadequacy*—moderate indication as noted in self-evaluation (C.Y.*V*=1, FV=3 of which 2 are questionable).

7. *Impulsiveness*—marked indication—as noted in a tendency to an unstable and labile type of affective reactivity (*C*.Y.V.=1; CF=4, —, 1) concomitant with no indications of any emotional adaptivity (FC=0).

8. *Introversion*—not apparent—experience balance approximately ambiequal (Exp.=6/5.5).

9. *Intellectual conformity*—very low (P=2)—extremely poor social adaptivity and much estrangement from the thinking of others.

10. *Neurotic trends*—marked—noted in this record in the marked obsessive-compulsive trends, aggression-hostility, passivity and anxiety, as well as in the personality conflict resulting from the interaction among these factors. Neurotic or color shock is suggested but not clearly delineated in slightly increased reaction times to cards XIII, IX and X, and in an extreme breakdown of intellectual control on card X.

Supplementary personality factors.

1. *Total affective reactivity*—marked (sum C=5.5).

2. *Affective control*—not apparent (FC=0)—see *Impulsiveness.*

3. *Fantasy activity*—marked (M=6)—inner living is rather abundant but considerably autistic.

4. *Intellectual control*—low (F+%=58)—ego strength is poor, especially for a person of superior intelligence, regard for reality being just below the critical minimum for the healthy.

5. *Intellectual adaptivity*—average level (A%=40)—adequate originality of thinking for a person of superior intelligence.

6. *Intellectual approach*—very markedly detailed (Dd!!! compulsive)—severely at the expense of the abstract (W) and somewhat at the expense of the practical (D).

7. *Intellectual drive*—low (Z=21, W=2)—especially so for a person of superior intelligence who shows very high productivity (see following).

8. *Productivity*—very high (R=68).

Subject 51M64

This subject's father had coronary artery disease and died of a myocardial infarction.

1. *Obsessive-compulsive trends*—little indication—as suggested in an experience balance which is not too far from ambiequal (Exp=6/7).

2. *Passivity*—marked indication—as noted structurally in great emphasis on shading determinants (FY=3, MF*Y*=2, CF.*Y*=2, Y=1) and suggested in passive trend to fantasy activity ("two butlers bowing to each other, two little shmoos just sitting and leaning forward, two little animals praying").

3. *Aggression-hostility*—a marked aggressive or resistance trend is structurally indicated in space determinants (S=5) and in this record would seem to represent strong will or determination. A very moderate degree of hostility is possibly suggested in the content of two responses ("two devilish girls with horns taunting each other, two quarrelous little bugs").

4. *Anxiety*—moderate indication—as noted in shading shock (considerably delayed reaction times to cards V and VII, reduced productivity on card V) and in extreme concentration upon affective dysphoria (sum Y=8, FV=6; see *Passivity* and *Feelings of inadequacy*).

5. *Feelings of inadequacy*—very marked—apparently implicit in an unusually large amount of self-evaluation (sum FV=6, —, 3) and suggested in the content of two responses ("animals seem to be trying to achieve this height or peak but legs are stuck or glued down, very lovely idea of a fountain shooting up—again you get the idea of something spending itself before it liberates itself—fountain peters out before it attains the height").

6. *Depressive trends*—moderate indication (see *Anxiety* above)—although affective dysphoria appears to be marked in this record, a quantitatively and qualitatively superior productivity precludes any depressive trends being more than moderate.

7. *Impulsiveness*—moderate indication—affective reactivity in this record is considerably released (sum C=7), part of it representing a controlled and adaptive type (FC=4) and part being of a more unstable and egocentric nature (CF=5, —, 1).

8. *Introversion*—not apparent—experience balance being moderately extratensive (Exp.=6/7).

9. *Intellectual conformity*—high (P=12)—excessive social adaptivity suggesting overconventionality.

10. *Neurotic trends*—moderate indication—as suggested in neurotic or color shock (breakdown of control on card II, delayed reaction times to cards VIII and X) and apparently extreme preoccupation with self-evaluation.

Supplementary personality factors.

1. *Total affective reactivity*—marked (sum C=7).

2. *Affective control*—moderate—some capacity for emotional adaptavity and control (FC=4) is accompanied by a considerable amount of a more unstable and egocentric type of affectivity (CF=5). (Also see *Impulsiveness*).

3. *Fantasy activity*—marked (M=6)—rather abundant inner living.

4. *Intellectual control*—average level (F+%=81)—good regard for reality.

5. *Intellectual adaptivity*—average (A%=40)—adequate originality of thinking for a person of superior intelligence.

6. *Intellectual approach*—moderately practical (D!)—but with some emphasis upon the abstract (W) and the detailed (Dd).

7. *Intellectual drive*—high (Z=53)—average for a person of superior intelligence.

8. *Productivity*—high (R=52)—commensurate with superior intelligence.

• • •

In contrast, two personality profiles are given which do not resemble the hypertensive or coronary type.

Subject 49M56

Both parents of this subject are in good health.

1. *Obsessive-compulsive trends*—no indication.

2. *Passivity*—little indication—as noted in very modest use of shading determinants both of which appear to be quite weak (FY=2) and suggested by some evidence of an oral trend in content ("dogs—kissing each other; girls—kissing again").

3. *Aggression-hostility*—moderate resistance (S=2) is supported by very moderate suggestion of an aggressive-hostile trend in content ("couple of animals sort of stalking their prey").

4. *Anxiety*—marked indication—as noted in some evidence of shading shock (delayed reaction time and suggested escape into rare detail on card IV, paucity of productivity on card VII), strong evidence of neurotic shock (see *Neurotic trends*), trend to specific anxiety indicator (Adx=1), considerable prevalence of human detail over whole human percepts (H=2, Hd=10) and general constriction of personality functioning (see *Supplementary personality factors* 1-8).

5. *Feelings of inadequacy*—little indication—as noted in one instance of self-evaluation (FV=1).

6. *Depressive trends*—marked suggestion—as noted primarily in general constriction throughout (see *Anxiety*).

7. *Impulsiveness*—not apparent—the very moderate amount of affective reactivity which is released (sum C=1) being entirely of an adaptive and controlled type (FC=2) and suggesting some degree of emotional rigidity. (Also see *Affective control.*)

8. *Introversion*—moderate indication—as noted in experience balance (Exp.=3/1).

9. *Intellectual conformity*—average level (P=8)—normal social adaptivity and conformity of thinking.

10. *Neurotic trends*—marked indication—as noted in strong neurotic or color shock (extremely delayed reaction time to card IX, somewhat delayed to card X; paucity of productivity on card VIII) and in marked anxiety and general constriction of psychic energies (see *Supplementary personality factors* following).

Supplementary personality factors.

1. *Affective reactivity (total)*—little (sum C=1)—affect being for the most part repressed.

2. *Affective control*—marked indication—what little affect is liberated being entirely of an adaptive and controlled type (FC=2) and suggesting some degree of emotional rigidity. (Also see *Impulsiveness.*)

3. *Fantasy activity*—moderate indication (M=3)—but inner living is considerably limited for a person of superior intellectual endowment.

4. *Intellectual control*—very high (F+%=96)—ego strength and regard for reality at the point of rigidity.

5. *Intellectual adaptivity*—(high) average level (A%=47)—but high for a person of superior intelligence—indicating some stereotypy of thinking.

6. *Intellectual approach*—moderately practical (D!)—at the expense of the abstract (W) and with normal attention to the detailed (Dd).

7. *Intellectual drive*—(low) average level (Z=26)—but far below average and quite poor for a person of superior intelligence.

8. *Productivity*—(low) average level (R=34)—but considerably under average and quite low for a person of superior intelligence.

Subject 51M43

Both parents of this subject were healthy.

1. *Obsessive-compulsive trends*—not apparent.

2. *Passivity*—moderate indication—as noted structurally in shading determinants (FY=4), in fantasy activity (flector M—"two figures kneeling over a campfire . . ") and in content of animal movement ("lambs lying down").

3. *Aggression-hostility*—moderate resistance is structurally indicated in space determinants (S=2) while a very moderate amount of hostility is suggested in associative content ("a couple of angry little figures arguing . . .").

4. *Anxiety*—marked indication—as noted in shading shock throughout (considerably delayed reaction times to cards I, IV, VI and VII; breakdown of intellectual control on cards I, IV and V; extreme emphasis on shading determinants on cards VI and VII).

5. *Feelings of inadequacy*—moderate indication—as noted in two instances of self-evaluation (FV=2).

6. *Depressive trends*—moderate indication—as noted in considerably delayed reaction times and emphasis upon dysphoric affect on the shaded cards (FY=4, FV=2).

7. *Impulsiveness*—moderate indication—what affective reactivity this individual shows is of a somewhat more unstable and excitable than an adaptive or controlled type (CF=2, FC=0). (Also see *Affective control.*)

8. *Introversion*—moderate indication—as noted in experience balance (Exp.=4/2).

9. *Intellectual conformity*—low (P=4)—poor social adaptivity.

10. *Neurotic trends*—marked indication—as noted in rather severe neurotic or color shock (extremely delayed reaction time to card III, extreme reduction in productivity on cards III and VIII, considerably delayed reaction times to cards IX and X) and in marked anxiety of a rather basic and deep-seated type (noted in shading shock).

Supplementary personality factors.

1. *Total affective reactivity*—little (sum C=2).

2. *Affective control*—not apparent (FC=0)—what little emotional reactivity exists is of a more egocentric than adaptive type (CF=2). (Also see *Impulsiveness.*)

3. *Fantasy activity*—moderate indication (M=4)—some evidence of inner living.

4. *Intellectual control*—low (F+%=60)—poor ego strength for a person of superior intelligence, regard for reality being at the critical level for the healthy.

5. *Intellectual adaptivity*—(low) average level (A%=38)—originality of thinking average for a person of superior intelligence.

6. *Intellectual approach*—approximately normal attention to the abstract, practical and detailed, with very slight emphasis upon the practical (D).

7. *Intellectual drive*—average (Z=34.5)—but rather low for a person of superior intelligence.

8. *Productivity*—(low) average level (R=32)—but low for a person of superior intelligence.

Discussion

The method of rating presented in this paper offers an approach to the comparison of Rorschach protocols in a systematic manner. It is not proffered as a rigid system, but as an initial attempt to supply a method for which there is great need. As indicated in Gildea's excellent review[27] which appeared after this study was under way, some such comparison is necessary if sensitive interpretation of the personality in different psychosomatic states is to be made. The ratings compiled by Gildea in his Table 2 of six personality factors similar to the writers' were all based upon subjective psychological interpretations, with a single exception.

The question of the validity of the writers' method of rating to obtain the dimensions of each personality factor as delineated by the Rorschach determinants remains unsettled. It is hardly surprising that the results are very similar to those of Molish et al.,[1] since the statistical analysis of the protocols of that group of Johns Hopkins medical students provided basic information contributing to the construction of the writers' yardsticks. The Rorschach technique is thought to provide insight into elements of the personality structure which are otherwise discernable only through similar projective techniques (such as the Thematic Apperception Test) or by the use of the psychiatric or psychoanalytic interview. Since time and opportunity for such extended studies have been out of the question, it has not been possible for the writers to make direct cross-correlations by any other established psychological method concerning these subjects.

The more superficial psychological tests such as the Minnesota Multiphasic Personality Inventory have not proved sensitive enough to provide a sound basis for appraising the validity of the writers' findings. A habit survey which has been systematically carried out during the study provides a certain amount of insight into some of the determinants under consideration. However, this survey is still in the exploratory stage, and is insufficiently standardized to provide a sound basis for determining the validity of the Rorschach data. As the number of subjects grows, consistent correlations with other data may indicate that the psychological categories here described have their counterparts in significant hereditary, physiologic or metabolic differences.

The writers' findings already suggest that certain personality traits are more prevalent among the offspring of parents with hy-

pertension or coronary artery disease than among those born of healthy parents. The final evaluation of the validity of the method awaits careful follow-up study of the subjects themselves to determine which ones are susceptible to, and which ones escape, future cardiovascular disease.

While the writers have used the terminology in current good usage in the Rorschach and psychosomatic literature to avoid semantic controversy, the "traits" under consideration might equally well be called "A," "B," "C" and so on. The precise definition of the "traits" may safely be left for future clarification. As long as the Rorschach determinants are clearly delineated and consistently applied, the yardstick should be a sound one.

Summary

To fill the need for a method of comparing a large group of Rorschach protocols, the writers have described a systematic way of rating certain component personality factors. While aware of the difficulties inherent in the isolation of these factors from the particular personality structures of which they are dynamic parts, it is thought that such a rating of Rorschach personality factors may be accomplished with a reasonable degree of validity. This differentiation may prove useful where comparison of the incidence of certain character traits with other data is desired.

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THE HUMAN NEED FOR RECONCILIATION: AS EVIDENCED IN THE DEVELOPMENT AND CURE OF PSYCHONEUROSIS*

BY IZETTE DE FOREST

Disharmony is for human beings unendurable.
—Otto Kant, M. D.

Human infants, with few exceptions, are born into the possession of the birthright of a loving environment. This is a continuance of the wholesome uterine existence. It may, in misfortune, last but a few days or months. It represents the "security" which our present-day pediatricians, psychotherapists and anthropologists are impressing upon us as essential to a child's health of body, mind and spirit. These specialists in human relations, however, have not, as far as the writer knows, explained why this birthright of love is basic to a developing life in the infant.

Perhaps it is considered a self-evident fact that to be surrounded by cherishing care allows and calls forth the response of love from the baby; and that this response, this extension of the baby's self, is of fundamental importance as motivation to each physiological system in his body, as well as to the mental and emotional areas of his personality. Drs. C. Anderson Aldrich and Mary M. Aldrich, in *Babies Are Human Beings,* say that at no time of life does the human being make such strenuous effort as in infancy. "He goes at his job in an intensely serious way." If we are unable to consider the growing process to be purely mechanical, we must seek an emotional motivation for this earliest serious endeavor.

It is the writer's suggestion that this motivation can be found in the infant's own need to love, to love himself in loving all who surround him. His every effort is outgoing; he becomes larger, in every sense of the word, from the moment of conception. He grows outward into the environment, taking up more and more space, coming into closer and closer contact with each detail of his surroundings. From the point of view of his emotional development the most important of such details are the human beings who are nearest to him. He extends himself toward them. This extension of himself in love provides the stimulus for the child's wholesome development of mind and body. It is the dynamo that

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transforms his energy. To secure this extension for the child, the environment must provide an embracing atmosphere, the baby must be loved. By this gift of love, the baby is assured of the opportunity to develop and express his innate capacity and longing to give love; and so to create in himself the emotional stimulus basic to healthy growth. As we well know, the act of loving stimulates one's whole being. The emotion of love vitalizes each physical and mental process.

There are few parents who cannot accept these fundamental facts and who cannot lovingly endeavor to provide such opportunity. The temperament of the infant inherent in his very growth, however, soon places stumbling-blocks in the path of the mutual relationship with those around him. Growth is a passionate process, as the Drs. Aldrich make clear, and implies a developing according to one's own inherited constitution. It is ruthless in its intensity; and hence, sooner or later, runs counter to the wishes and demands of the human environment, as well as to the laws of the physical world. The security of the baby's birthright of total love may be, as a result, slowly, or on occasion suddenly, withdrawn.

It may be that the infant's nature in conjunction with the temperaments of his parents makes inevitable this blockage, often resulting in disastrous character deformation. On the other hand, it may be that external circumstances produce this unfortunate effect; as in the case of a two-year-old boy, whose younger and only sister was born with a club foot. This little boy suffered a traumatic rejection by his parents in favor of his sister. A thwarting block was erected in the path of his healthful development. It was then essential for him to devise a new path of growth unconsciously; for life persists, whether moving forward or backward or at a tangent. A neurotic organization, or, as Dr. Andras Angyal* defines it, "a neurotic way of life," was established by this child, and a severely distorted personality was put into process throughout his early years, continuing into adulthood.

There is in everybody's human experience, and at an early age, a traumatic moment, or a series of such moments, in which the significant human figures are at serious odds with the child. It is then that the basic need of the child to express his love, and so to stimulate his wholesome growth processes, experiences at the least

*Angyal, Andras: The convergence of psychotherapy and religion. J. Pastoral Care. 1952.

a loss of nourishment, at the most a cruel frustration, a harsh stoppage. This moment represents "disharmony" and is unendurable to the child. It represents an emotional suffocation, or, as it were, an emotional blocking of blood to his heart. It is not surprising that the heart from earliest times has been the organ used to symbolize the source of love.

If disharmony is unendurable to human beings, an attempt must always be made to undo the harmful condition. Here the need for reconciliation comes into play. Reconciliation is defined as "the act of restoring friendship." And this is exactly what the infant or young child attempts to do. His need to love is so imperative that he is unconsciously willing to sacrifice his own nature in order to yield his will to that of his parents, to learn how to become the child whom they will accept with love. No effort is too great to achieve the restoration of this friendship, to find value again in his parents' eyes. His behavior, the nature of his thought processes, his standards of value, even the choice of what emotions to allow into consciousness and to express, gradually become the basis of his re-formed personality. He may lose all originality of thought and of imagination; he may become an unfeeling person, almost totally devitalized; he may suffer from chronic psychosomatic illness. This change of personality in many cases forms the initial step in the structuring of a neurosis, "a consistent process with its own logic and laws," as it is described by Angyal.

The two-year-old boy, mentioned in the foregoing, learned from his tragic rejection, to base his entire behavior and eventually his moral principles upon the standards of his parents: as for example, that the one crime to be avoided was that of "hurting the feelings" of another person. In his case, this meant the hurting of his sister's feelings and, more important, those of his mother, who with exaggerated sensitivity believed that she, and she alone, was responsible for her daughter's deformity. Trained never to hurt the feelings of another, he was forced to practice deception, to lie and to steal. His natural curiosity was diverted into voyeurism. His mental equipment, of unusual caliber, was narrowly devoted in early adulthood to the solving of the scientific problems of human communication, propaganda, etc. He suffered from sexual impotence and from an inability to sense in himself either anger or love. His emotional life, what little there was of it, was devoted to long associations with difficult personalities, whom he

wooed and studied assiduously, attempting, but without success, to communicate with them, to adjust to their neurotic complications. He had created for himself a sterile life.

The human need for reconciliation can thus be seen to form one of the basic origins of psychoneurosis. It again comes to light under the conditions of a full-blown neurosis, when the sufferer is finally forced to accept his need for help. For here the primary difficulty is always and inevitably one of unhappy, unsuccessful interpersonal relations. There is no neurotic sufferer who is not to a large extent incapable of living at peace and in loving-kindness with his fellow-men. This is the very core of his neurosis. This is his basic complaint when he asks for psychotherapeutic assistance. Again he seeks to become reconciled; he seeks harmonious relationships with the significant figures of his environment.

Having in his childhood sacrificed his true nature in order to regain the friendship of his parents, the neurotic has continued along the unwholesome tangential path of development, upon which he then embarked. His innate temperament in later years increasingly suffers distortion in the belief and hope that all humans with whom he comes in close contact will be consistent with those of his childhood, to whom he had attempted to adjust; will make the same demands; will accept his constant endeavor to yield to their wishes; and will at long last love him in return for his self-sacrifice. The unhappiness that has always accompanied this unavailing sacrifice, the sense of self-blame and the unconscious guilt for the self-imposed betrayal of his true nature, have however constantly prevented his earning the longed-for acceptance. For in the development of his neurosis he has become an unloving person, impossible to love in return. This is paradoxically a repetition of the early experience of failure, when he initially forced himself to deviate from his true path of growth.

The great sacrifice, made as a little child, has not succeeded; for in the neurotic's urgent need to be loved, so that in turn he might extend himself in love, he has compelled himself to proceed along his chosen neurotic pathway through adolescence and adulthood. The constant experience of failure, however, finally overcomes him and, admitting the disharmony of his life, he asks for help. Each neurotic patient questions: "How can I succeed in friendship? How can I restore, how can I learn to nourish, my personal rela-

tionships? I'm at my wit's end in my relation to my children, my spouse, my friends, my boss, etc.!"

The third appearance of the need for reconciliation comes during successful psychotherapeutic treatment and in a new form. In contradistinction to its motivation in the creation of neurosis and to its motivation in seeking therapeutic aid, we now find it as one of the final signs of "cure."

It can be said that the psychotherapeutic process is one of establishing for the first time in the patient's life a successful and enduring interpersonal relationship. It consists of a mutual study of the patient's character distortions as they are seen in their incipience in early childhood, as they have compulsively developed throughout the patient's later years, and as they are expressed in the patient's experience during therapy, both external to the therapist's office and in increasing intensity toward the therapist himself in the transference phenomena. These distortions do, in fact, in the process of therapy wear themselves thin. They prove of no avail in the therapeutic relationship, neither forcing the therapist to yield to their pressure nor eventuating in his rejection of the patient. The former outcome would represent to the patient his final acceptance as a distorted personality; the latter would represent the now familiar failure.

The inefficiency of his neurotic way of life, realized in the therapeutic relationship itself, results in a slow admission by the patient of his longing to give it up, of his longing to start again as a little child upon the path of healthy growth from which he had forced himself to deviate. This admission represents the regaining of his integrity, discarded in his earliest years. He now embarks upon his new program with renewed energy; upon the adventure of pursuing a life that is in accord with his constitutional nature and potentialities. This new and wholesome way of life he offers, in growing confidence and as a successful venture in friendship, to his therapist. The essential need at this juncture is soon recognized as the same need sensed by the infant; the need to extend his true self toward his environment. He wishes to learn to love, to stimulate love in others so that he may express himself in love, so that he may create in himself the motivation that is essential to wholesome growth.

This final stage in psychotherapy is a period of research in interpersonal relations; in seeking to become reconciled. The many

unsuccessful relationships of the past are passed in review, are examined and re-evaluated. An attempt is made with fresh eyes and maturing emotions to put the blame where it belongs. Soon it becomes manifest that this is fruitless; that this is indeed out of line with the need to develop in loving-kindness. Forgiveness of the mistakes in the tragic past becomes a needed expression of love. And, with forgiveness, the past is recognized in a new light. In the newly-recovered endeavor to live lovingly with one's parents, if only in memory, and with one's self, the patient becomes aware that in all human beings there is true goodness, "that of God in every man."

The same train of emotional events takes place in regard to contemporary relationships and, last of all, in regard to the therapist. Here mistakes and misunderstandings, by both therapist and patient, over the long period of therapy are mutually admitted, regretted and forgiven. True reconciliation is thereby achieved and with this achievement there is echoed the words: "Therefore if thou bring thy gift to the altar, and there rememberest that thy brother hath ought against thee; leave there thy gift before the altar, and go thy way; first be reconciled to thy brother and then come and offer thy gift."

The success, long sought, of learning to restore friendship, but without betraying one's integrity, opens wide the gate to the recapturing for one's self of one's initial birthright. In extending one's self in loving-kindness according to one's true nature, one creates that very environment of love which in turn invites the continuing fulfillment of one's loving potentialities. This is the gift which one brings to the altar; the gift which one offers to God.

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SOCIO-PSYCHIATRIC OBSERVATIONS ON DISPLACED PERSONS

BY H. E. LEHMANN, M. D.

The observations to be made in this paper are based on a study of more than 50 "normal" and 37 psychotic displaced persons. All of the subjects were either domestic or nursing employees of Verdun Protestant Hospital, Montreal, P. Q., or were admitted as patients there. Contacts with the subjects covered periods ranging from one month to more than three years. With most of them, daily contact was maintained over several months.* The purpose of the paper is to outline:

I. The distinctiveness and uniformities of the situations experienced by the displaced persons group, prior to and consequent to their admission to a recipient country.

II. The psychodynamics of the adjustments made by the displaced person to a recipient country.

III. Special problems appearing in the treatment situation, with a note on the challenge of "the stranger" to the therapist.

IV. A tabular presentation of diagnoses and results of treatment with reference to psychotic displaced persons.

I. The Displaced Person as a Distinct Phenomenon

The displaced person is like the political refugee and the ordinary immigrant in that he leaves the land of his birth and starts life anew in an alien country. There, however, the likeness ends. The immigrant moves of his own volition, at least is not aware of any compulsion. The political refugee may be compelled to migrate, yet he is regarded by himself, and often by persons in the recipient country, as a hero, or at least as a martyr. The immigrant and the refugee usually come to the new land intact, with papers and passports which formally establish their identities and their claims as members of sovereign states.

The displaced person, by contrast, is one who is faced with the loss of his whole standing. He has usually no financial resources or material goods and is devoid of formally recognized civil or political status. The displaced person has no passport and no consular representation; more often than not, he has no surviving

*While this study was in progress, Dr. L. Tyhurst of the Royal Victoria Hospital undertook the investigation of displaced persons in the same locality, Montreal. Most of her psychiatric patients were suffering from various psychoneuroses.

family. Unlike the political refugee, he represents no cause, receives no kudos; unlike the immigrant, he is painfully aware that his mobility did not originate from his own free choice.

Displaced persons, in many respects, are a remarkably homogeneous group. They have all had acutely stressful experiences, they have been "equalized" through the years spent in camps where the customary distinctions of social status were meaningless and largely inoperative, they possess uniform material resources: nil. Finally, the displaced persons who migrated to Canada were not free agents with respect to choice, duration or location of occupation, nor, consequently, of place of residence, these matters being stipulated in the contracts signed by the subjects before leaving their camps in Europe.

The psychodynamic situation is very similar, however, in the case of any immigrant who does not share the special added handicaps of the displaced person; and the dynamic sequence of psychological reactions and counter-reactions which will be outlined in the following is valid for most immigrants, though less distinct in them than in the displaced persons.

II. The Psychodynamics of Adjustments of Displaced Persons to the Recipient Country

The period ranging from three to six months after the arrival of the displaced person may be termed "the critical period of adjustment." It is within this period that the reactions, to be described as "primary," have usually run their autonomous course. Within this period, also, the displaced person is most vulnerable to traumatic factors in the environment. However, some subjects, who do not manifest the primary reactions during the critical period, may have delayed reactions, identical in nature, a year or more after their arrivals.

Pathological reaction types of displaced persons may be described as *Primary reactions*: Depression. Anxiety. *Secondary reaction*: Hostility. *Specific reactions*: Hysterical, and other psychoneurotic reactions, usually associated with somatic symptoms. Paranoid attitudes. Psychoses.

The distinctions among these reaction patterns are both etiological and distributive; thus, primary reactions are the most fundamental as well as the most frequent.

Primary Reactions

Depression is a highly-generalized reaction among recently arrived displaced persons. It is a "normal" response to the major loss of libido objects—family, material goods, homeland, security, and status. The displaced person must also adjust to the virtual loss of his native language and often of that most elemental item of identification, his name. Natives of the recipient country unwittingly contribute to this latter phenomenon by Anglicizing difficult European names, or by addressing the displaced person by the Christian name instead of the surname—prefixed with the appropriate Mr., Mrs., or Miss. This practice, while often intended as a gesture of friendliness, is not usually accepted as such by the displaced person who is accustomed to the more formal European etiquette.

Depression is manifested by loss of sleep and appetite, moodiness, crying spells, asocial behavior and lack of initiative. Somatic complaints are an almost universal feature, and the general physical resistance is lowered significantly. Prins,[3] in giving a psychological analysis of his own experiences, during his escape from German-occupied territory, illustrates this vividly when he reports that under these conditions, the simple extraction of a dental root from his mouth, which ordinarily would hardly have interfered with his life routine, produced "a virtual nervous breakdown" and forced him to go to bed for several days.

Anxiety is almost universal among the displaced persons observed. This reaction would seem inevitable in view of the frustrations suffered, in view of the break-up of such routines and sentimental relationships as had been established in D. P. camps, and, above all, in view of the new and unfamiliar environment. Objectively, the sheer strangeness of the recipient country, combined with the factual poverty of resources at the command of the displaced person and his total dependence upon this unfamiliar environment would seem necessarily to produce that feeling of an insuperable, poorly-defined but overwhelming situation which registers as anxiety. The language barrier alone certainly accounts for strong feelings of embarrassment and apprehension.

Forms which anxiety took, in the group studied, included sleep disturbances, nightmares, psychosomatic complaints and acute anxiety attacks. It is interesting to note that, when given a chance to express themselves freely, as in fingerpainting, displaced per-

sons often produce scenes which include fences or unopenable doors, apparently symbolic representations of their feeling of being on the outside of things, excluded. Repeatedly such persons complained of feeling physically cold, although no cause for it could be found in their environment. These complaints must probably be interpreted as an expression of the feeling that there is not enough emotional warmth in their surroundings.

Secondary Reaction

Hostility. The frequency, duration and degree of hostility manifested by displaced persons are much more dependent on the response of the specific environment than are the primary reactions. Nonetheless, hostility may be assumed to be widely prevalent among displaced persons during the critical period.

The specific social environment provokes hostility in displaced persons for a variety of reasons. There often tend to be hostile and jealous reactions toward the displaced persons, especially when the latter turn out to be young, healthy, attractive and well-dressed instead of the pitiable product of the concentration camp which is evidently one of the stereotypes formulated by North Americans regarding displaced persons. Related to this stereotype, is the expectation, held by many natives, that displaced persons should feel and should exhibit a deep sense of gratitude and obligation for the privilege of being admitted to the recipient country. The communication of such expectations to the displaced person commonly causes that person to react with resentment and hostility, which, in turn, automatically induces hostile reactions in the native whose national sentiments have been outraged.

However, it is evident that much of the hostility from the social environment is brought upon the displaced persons through their own criticisms, complaints and derogatory remarks, which, often enough, lack objective grounds. The displaced person, like the orphaned child, seems to hold a grudge against the world, and is jealous and covetous of almost everyone, since anyone seems wealthy and secure to the displaced person, compared to his own plight. The displaced person's constant complaints, his almost irrational tendency to criticize and belittle the food, the climate, the people, their education, their customs, and numerous other aspects of the recipient country, are hostile reactions which arise basically from the feelings of degradation, of hopelessness, of envy and of

frustration which the displaced person generally experiences during the critical period.

In Canada, one source of hostility by displaced persons has been the enforced lowering of status arising from the objective situation in which many have been unable to work at the tasks in which they were skilled in Europe, and have consequently suffered degradation from being compelled to work at jobs they regarded as menial.

It can be concluded that when the hostile attitudes of the displaced person are seriously inflamed by hostility from the social milieu, a vicious circle may result, which may retard, or permanently impair, the favorable adjustment of the displaced person. On the other hand, it has been pointed out by B'rakhyahu,[3] that those who show emotions of violent hatred and resentment usually have a better prognosis with regard to final adjustment than those who display despair or apathy.

Specific Reactions

Contrasted with the primary and secondary reactions, which are almost universal among displaced persons, are the specific reactions. These reactions are not generalized, but manifest themselves only in those persons constitutionally predisposed by unique constellations, organic and experiential, which probably antedate the displaced person status.

Hysterical and psychosomatic symptoms are the commonest of the specific reactions. They have been studied by Tyhurst.[1] Paranoid attitudes, without psychotic disorganization of the personality, occur in many displaced persons.

Handicaps in communication were mentioned previously as one source of anxiety. Paranoid traits, in the displaced person, seem also related to handicaps in communication. Kraepelin's paranoid reaction of deaf persons (homilopathy) and Aller's[4] psychogenic paranoid breakdowns in prisoners-of-war, who were isolated with regard to their language, are conditions similar to those found in displaced persons. Thus both the displaced person and the deaf often react to this communication handicap with a tendency to be distrustful of others, and to be oversensitive and constantly on their guard against easily imputed ridicule or exploitation. However, the view is held by the writer that, despite the evident relationship between communication handicaps and development of

paranoid traits, actual paranoid breakdown occurs only in those constitutionally predisposed.

The question arises as to why the displaced person does not usually manifest his symptoms prior to his arrival in the recipient country, since most of his losses have taken place years before his arrival. The answer seems to be that as long as life conditions are arduous and insecure to the degree where sheer physical survival is the dominant drive and goal, many of the psychic functions are, as it were, anesthetized or inhibited, so as to facilitate maximum efficiency of those functions vital to survival. Kral[5] has described striking observations of this phenomenon under the stressful conditions of existence in the Nazi internment camp of Theresienstadt. As soon as greater material security comes to hand, however, the displaced person's losses and traumata rise prominently into consciousness and monopolize it during the critical period.

III. Special Problems of the Treatment Situation

The displaced persons have presented those who have been responsible for their welfare with unaccustomed problems. Even if they have not required psychiatric therapy, they have presented a difficult task to the social agencies and to the social workers who have been alert to this challenge and who soon succeeded in working out their own techniques of case work with these troubled individuals (Kage,[6] Spalding[7]).

Depression. Experience has shown that little can be done about depressive states, which tend to be self-limiting. The general adjustment prognosis is poor if the depression has not run its course within six months from its inception. The prognosis is extremely dubious if the subject suffers any additional trauma, such as the death of an emotionally valued friend or relative, during the critical period.

Anxiety and Hostility. Anxiety can be lessened by reassurance and by clarification. However, maximum care should be taken to distinguish between anxiety and hostility, since clarification is strongly contraindicated when dealing with hostility in the displaced person. Important elements in the situation, unless consciously recognized, may well bias the therapist in favor of clarification, rather than the techniques actually required—passive acceptance and ventilation. The elements referred to here are a dynamic feature inherent in the treatment of "the stranger."

In this context the "strange" denotes any unfamiliar object or situation, or any alteration in the configuration of objects constituting a familiar situation, which is not readily definable in terms of the previous experience of the individual. The strange is the unfamiliar, conceived of as an irreducible experiential quality. The "stranger" is the strange, embodied in human form.

The stranger tends generally to arouse primitive fear responses in the native, and this fear almost invariably calls up hostility in the native, as a primitive, practical and easily available defense, whenever the stranger is in the minority.

Applying these notions to the relationship between therapist and the displaced person, it is suggested that some therapists may be as yet unfamiliar with, and unable to assimilate, the emotional implications of the stranger-problem as a facet of psychotherapy. Specifically, it is suggested that unless the therapist recognizes and accepts that, he himself is likely to react with hostility to the stranger, unless the therapist becomes as shock-proof against, and as sophisticated about, these primeval reactions as he is with regard to sexual and other well-explored emotionalized complexes, he is likely to be severely handicapped in his treatment of the displaced person. Failing such awareness of his own reaction tendencies in this situation, the therapist may find himself driven to clarify the anti-native hostility of the displaced person and to justify such clarification in terms of the dictates of standard therapeutic procedure, whereas, in fact, the therapist would merely be rationalizing his own ethnocentric sentiments, which had compelled him to defend his culture against the attacks of the stranger.

The conclusions to be stressed, in view of the previous statements, are that in dealing with manifestations of hostility on the part of displaced persons, passive acceptance and ventilation are the techniques indicated. In practice, it has often been found advisable for the therapist to over-identify with the subject, and to join the latter in his verbal attacks upon various objects in his life situation. This process of participant over-identification is continued until the displaced person himself questions the objectivity of the hostile statements echoed by the therapist, and himself reformulates them in terms more appropriate to objective reality.

IV. The Presentation of Diagnoses and Results of Treatment with Reference to Psychotic Displaced Persons

It is very difficult at this stage to determine the exact number of actual breakdowns in displaced persons, since comprehensive records are not yet available. The question of how many displaced persons require psychiatric treatment is often asked, and the psychiatric out-patient clinics of general hospitals in the larger cities on this continent seem to take care of a sizable number of such new arrivals. While it appears probable that the percentage of displaced persons requiring psychiatric treatment at some time during the first year after their arrival in the new country is larger than that of a matched group of the native population, it seems that the incidence of psychotic breakdowns among displaced persons is not greater than in the general population.

Between 1948 and 1951, the majority of acutely psychotic displaced persons in the Montreal area, which serves as one distribution center for the whole of Canada, were admitted to the Verdun Protestant Hospital. The accompanying tables give the distribution and frequency of psychiatric diagnoses, and symptoms in a group of 37 displaced persons, that is, the total number admitted to that hospital between June 1948 and December 1951.

It is evident that paranoid, depressive, and anxiety symptoms prevail among the psychotic individuals as they do among the psychoneurotic and "normal" displaced persons. Schizophrenia is the diagnosis in more than half of the Verdun hospital's psychotic displaced persons but it must be remembered that this group is selected with regard to age; since most of these people were in the age range between 15 and 40, one would expect such a distribution.

Of the 37 patients, 23, i. e., 62.2 per cent, were discharged as recovered or greatly improved. Most of them spent less than six months in the hospital. If one considers the fact that many of these patients had no family connections in this country and had only made tentative economic and social adjustments to the new environment at the time of their breakdown, this rate of recovery appears rather favorable.

Four patients were repatriated. One was deported on the request of the family who felt that the girl would have a better chance to avoid a relapse if she returned to Europe. A second was deported after having been arrested several times for various

disturbances. In the third case, it was discovered that the patient had been psychotic before leaving Europe, and the fourth patient was mentally deficient and unemployable.

Table 1. Nosological and Symptomatic Diagnoses of Psychotic Displaced Persons Treated at Verdun Protestant Hospital, Montreal, Between June 1948 and December 1951

Name	Diagnosis	Symptoms
H. A.	Schizophrenia	Paranoid reaction
F. A.	Involutional depression	Depression, anxiety
A. B.	Schizophrenia	Paranoid reaction, anxiety
A. E.	Schizophrenia	Catatonia, hysteria, anxiety
N. F.	Paranoid condition	Paranoid reaction, depression
M. G.	Schizophrenia	Paranoid reaction
A. G.	Reactive depression	Depression, hysteria
E. H.	Conversion hysteria	Hysteria
M. H.	Schizophrenia	Catatonia
A. H.	Schizophrenia	Hebephrenia
M. I.	Anxiety hysteria	Hysteria, anxiety
P. J.	Schizophrenia	Paranoid reaction
K. K.	Schizophrenia	Catatonia
S. K.	Manic-depressive psychosis	Depression
H. L.	Schizophrenia	Hebephrenia
I. L.	Manic-depressive psychosis	Depression
P. M.	Manic-depressive psychosis	Manic reaction
E. O.	Schizophrenia	Catatonic excitement
P. O.	Schizophrenia	Paranoid reaction
O. P.	Schizophrenia	Depression, paranoid reaction, anxiety
A. R.	Psychopathic personality	Paranoid reaction, anti-social reaction
J. R.	Schizophrenia	Paranoid reaction, anxiety
H. R.	Schizophrenia	Depression
L. R.	Manic-depressive psychosis	Manic reaction
K. R.	Manic-depressive psychosis	Depression, anxiety
J. R.	Schizophrenia	Catatonia, paranoid reaction
D. R.	Postpartum psychosis	Depression, anxiety, paranoid reaction
E. R.	Schizophrenia	Hebephrenia
S. R.	Schizophrenia	Paranoid reaction, anxiety
M. S.	Schizophrenia	Paranoid reaction
J. S.	Psychopathic personality	Hysteria, anti-social reaction
N. S.	Reactive depression	Depression, paranoid reaction
W. S.	Manic-depressive psychosis	Depression
M. T.	Reactive depression	Depression
L. V.	Cerebral arteriosclerosis	Organic syndrome
H. V.	Schizophrenia	Catatonia, paranoid reaction, anxiety
M. W.	Schizophrenia	Paranoid reaction

Table 2. Distribution of Symptoms Present in a Group of 37 Psychotic Displaced Persons

Paranoid reaction	16
Depression	12
Anxiety	10
Catatonia	6
Hysteria	5
Hebephrenia	2
Anti-social reaction	2
Manic reaction	2
Organic syndrome	1

Table 3. Distribution of Diagnoses in a Group of 37 Psychotic Displaced Persons

Schizophrenia	20
Manic-depressive psychosis	6
Reactive depression	3
Hysteria	2
Psychopathic personality	2
Paranoid condition	1
Involutional melancholia	1
Postpartum psychosis	1
Cerebral arteriosclerosis	1

These psychotic patients received the usual treatment during acute illness, that is, electric convulsive therapy, insulin coma therapy, occupational therapy, group psychotherapy, and in a few cases where the language difficulty could be overcome, individual psychotherapy. It was interesting to observe that a number of these patients went through a phase of extraordinary psychomotor excitement when regaining consciousness after electric convulsive therapy or when waking up from insulin coma. They were violently aggressive, and misidentified the medical and nursing personnel. Later, they would explain that they had thought that they were in concentration camp and had to fight their way out. If these abreactions were handled with a minimum of restraint, they usually subsided within a few minutes, but they tended to last longer if inexperienced nurses or attendants applied unnecessary coercion.

Discussion

The literature on psychoses in persons who are removed from their home environments is mainly concerned with those paranoid reactions to which Schneider,[8] following Kretschmer's terminology

refers as "primary delusions of reference." According to him, they are characterized by the development of ideas of reference and persecution on the basis of reactive anxiety, rapid subsiding of the acute phase and final recovery with complete insight. Among 27,000 admissions between 1919 and 1929, in Germany, Schneider could collect only three cases of this type. Later Knigge[9] published a report on a case of the same kind and after the Second World War, Pedersen[10] and Kino[11] described similar reactions, referring to them as refugee neurosis and alien's paranoid reaction. Jaspers[12] distinguishes between psychoses due to disaster, those due to nostalgia and those due to isolation, and he points out that the first type is often characterized by apathy or stupor, the second by acts of impulsive violence and suicidal attempts and the third by paranoid formations. The background of the writer's displaced persons always combines elements of disaster with those of nostalgia and isolation.

Frost[13] analyzed the psychotic reactions of a group of homesick German and Austrian immigrant girls who had voluntarily gone to England to accept positions in domestic service. In his opinion, heredity played a minor role in these breakdowns, and a similar statement is made by Pedersen. Pedersen also believes that people belonging to the middle class are slightly more vulnerable under the conditions of displacement stress than persons belonging to other social strata. Of Frost's cases, about two-thirds recovered. This figure is very close to the recovery rate in the writer's own material. Suicidal tendencies were not seen so frequently among the Montreal patients as in Frost's material. Another difference becomes apparent, if one notes that Frost regarded repatriation as a significant and highly therapeutic measure, while the deportation of the writer's patients always represented therapeutic failure.

Summary

The displaced person constitutes a special entity and in certain aspects is different from the refugee or voluntary immigrant. Most immigrants, and displaced persons in particular, are subject to manifestations of temporary maladjustment, which may be divided into primary, secondary and specific reactions. The psychotherapeutic handling of such persons presents a special challenge to the therapist, who is often not sufficiently aware of his own ethno-

centric bias. The incidence of psychotic breakdowns among displaced persons is probably not higher than in the general population. The recovery rate among psychotic displaced persons compares favorably with that in other psychotic groups. Schizophrenia was the prevalent diagnosis, and paranoid, depressive and anxiety symptoms—in this order—were the prevalent symptoms in a group of 37 displaced persons suffering from psychoses.

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ENVIRONMENT, A RESPONSIBLE AS WELL AS RECONSTRUCTIVE FACTOR IN MENTAL DISORDER

BY JOSEPH MECHLOW, M. D.

Introduction

According to various outstanding authorities the complete psychoanalytic investigation of behavior has three aspects: a dynamic aspect, which is the description of a specific reaction as the outcome of an interplay of forces; a historical aspect, which is the tracing back of a specific reaction's occurrence to earlier situations; and, finally, a genetic aspect, which is the exploration of the questions, of when, why and how this particular form of behavior was first established.

In this paper emphasis will be laid upon the dynamic aspect and its place in the therapeutic effort of the state hospital. In the state hospital, in the majority of cases the therapeutic effort is directed almost exclusively toward the diseased individual, minimizing the fact that the specific reaction treated is the result of an interplay of forces of which the patient represents just one factor, while his environment represents a factor of practically equal importance.

To illustrate this interplay of patient-environment forces and its therapeutic outcome the following three cases have been selected as representative samples of a larger group of one hospital's patients—Hudson River State Hospital, Poughkeepsie, N. Y.

Case 1

Dorothy B., a 48-year-old clerk, was diagnosed as dementia præcox, paranoid type.

Dorothy's family history indicated some basis for her mental disposition. There is a mentally ill cousin, a son of a paternal aunt. Dorothy's father was a "poor mixer" and "highly nervous." The mother, a rather poorly educated and excitable woman, was a tiresome talker who often challenged Dorothy's tolerance. There were two sisters, one of them apparently the most stable member of the family until her husband was called into the armed service. Dorothy herself was a poor mixer and sensitive. Despite this unfavorable background, she apparently was well adjusted until the age of 25 when she married and left her home.

In 1929, she went to live in her husband's home, and at that time her first mental reaction occurred. It never was brought out whether sexual or other difficulties precipitated this first episode. For a period of about six weeks, Dorothy complained of severe headaches and sleeping difficulties. In 1937, there was a second similar attack which lasted six months. It was precipitated by her husband's frequent unemployment, and it was then that Dorothy gave up the job she had held for 17 years. She reasoned that, by her doing so, her husband might be forced to become a better provider. In 1944, her father's death precipitated a third attack which, first mild and seemingly subsiding, soon flared up again violently with symptoms of frank psychosis.

Dorothy expressed severe antagonism toward her husband and had to be hospitalized in Hudson River State Hospital in February 1946. During her stay there, she minimized her marital difficulties and admitted only vaguely that her husband and his family were "different" from her and her family. Following about three months of hospitalization her acute symptoms subsided and on request of her husband she left on convalescent care in his custody.

Only two days after having returned to her husband's home, there was a sharp relapse, and Dorothy had to be rehospitalized. On her return to the hospital, she strongly indicated: "My problem is my husband. I don't want to return to him. I would like to go home and live with my mother." After three more months of hospitalization she again appeared sufficiently improved to leave on convalescent care and, by mutual agreement between Dorothy and her husband, went to her mother's home.

In her mother's home she remained well adjusted for the following three years, which was exactly the time it took to obtain her divorce. During these three years she was practically every day and all day preoccupied with plans and steps to accomplish her divorce, and was sympathetically and actively supported by her mother.

However, the instant she obtained the divorce there was a recurrence of her old somatic symptoms. Later, commenting on her feelings at that time, Dorothy remarked, "I felt I was single again and I was worrying about sitting around and not getting married again." Having solved one problem she apparently realized, then, that she had to face a new and at least equally difficult problem, that of becoming remarried.

At that point, Dorothy's and her mother's objectives diverged. Dorothy, with her schizoid make-up, had increasing difficulties in making new contacts and became more and more irritable. But as she never verbalized her problem, her aging mother became concerned about Dorothy's changed behavior and, misinterpreting it, felt Dorothy needed some kind of diversion and thought the best would be employment. It was merely that constant suggestion which added to Dorothy's irritability—because she had felt so many years badly exploited by her husband.

The friction between Dorothy and her mother increased necessarily, and finally reactivated her trend reaction to such a degree that she had to be readmitted in October 1951.

The course of this case demonstrates that an increasing emotional antagonism in the marital setting was at least contributory to Dorothy's first reaction and its repeated reactivation. On the other hand, her home situation prevented a relapse as long as it was sympathetic with Dorothy's emotional needs and acted synergistically with her strivings.

Case 2

Lillian B., a 54-year-old practical nurse, was diagnosed as a case of involutional psychosis, paranoid type.

Nothing was known concerning Lillian's remote ancestry as both her informants and Lillian were in general evasive.

In 1913, when Lillian was 15 her father died, allegedly of accidental drowning. At that time her mother was pregnant, and Lillian felt that "I as the oldest of the family had a duty and responsibility to stay with my mother and help my family." First she helped to raise her sisters and brother; and later, when they were grown, she went to their various homes, now helping them to bring up her little nieces and nephews.

In 1934 after her mother's death there was a good deal of an argument concerning the settlement of her parents' estate and on that occasion, being then 36, Lillian realized that she was about to pass up her own chances of becoming married. She began to associate herself with a man of her community, first working for him, later paying his bills, and finally making him a joint owner of her home by means of a deed. This situation caused considerable concern to her sisters and became the basis of a severe and constant conflict between them and Lillian. Lillian rationalized their attitude by saying: "They never wanted me to settle down be-

cause the way it was it always was convenient to them." However, with regard to her man friend's attitude, she conceded that despite all her sacrifices, "He never offered to marry me but I always have hoped, maybe one day he will." Her sisters, considering the situation more realistically than humanely, continued to present Lillian with more evidence of her futile and misused efforts, and Lillian, torn between their arguments and her own need for at least illusional gratification, had a first mental breakdown in 1940 and another one in 1945 when she was admitted to Hudson River State Hospital.

In 1945, subsequent to four months of hospitalization, it was felt that Lillian had improved sufficiently to leave the hospital on convalescent care in custody of the sister with whom she had lived before her admission. The first few days at her sister's home, Lillian had crying spells, and hardly three months elapsed before she had to be returned to the hospital.

After only two more weeks of hospitalization she was so well that convalescent care was again considered, but as she refused to return to her sister's home she left in custody of her uncle. At her uncle's home she made an excellent adjustment for the following six years, as Lillian's "friend" was also her uncle's and aunt's friend. Both uncle and aunt actively and unscrupulously promoted Lillian's relation to him. Although this friendship obviously became strenuous at times, as Lillian had to work hard to raise all the money needed by her friend, and even mortgaged her home, apparently no adverse reaction occurred. She seemingly was relatively well satisfied with her illusional and unshakable hope.

In August 1951 her sisters' growing concern about Lillian's dependency upon her friend reached a climax, and they decided, at any expense, to bring Lillian back to their home and her senses. Pretending that one of their children had become ill they invited her for a visit, and, once she was there, the old discussion started all over again, with the result that Lillian's old trend and agitation were reactivated, and she had to be rehospitalized in October 1951.

The course of this case demonstrates that the persistent emotional antagonism at Lillian's home was at least contributory to her reaction and its reactivation. All the good intentions of Lillian's sisters did not outweigh their antagonism toward the most vital emotional issue in Lillian's life. On the other hand, an en-

vironment offering nothing more than illusional gratification of Lillian's emotional needs was good enough to prevent her from any relapse, despite increased stress and strain.

Case 3

Anne D., a 39-year-old saleswoman, was diagnosed as a case of manic-depressive psychosis, circular type.

Anne's home setting was characterized by a father who was stable, conscientious and overprotective and a mother who was ambitious and domineering. There was one brother, a physician who was of superior intelligence, stable and serious minded.

Anne was described as a good but fearful child who frequently slept with her mother. She followed her brother in classes but, in contrast to him, was a poor student. Studies were difficult, for in the home as well as at school she frequently was unfavorably compared with her brother who had been a pet of the teacher. As a result, she did not develop any intellectual interest at all but compensated by being highly ambitious socially and becoming very popular with the other students.

At the age of 18 she became engaged to a law student who after a courtship of six years, left her to marry another girl. Through losing her fiance she not only suffered a painful emotional loss but, simultaneously, failed to escape from the restrictive atmosphere of her parental home. As a result she became depressed and suicidal.

In 1939, at the age of 26 she had to be admitted to a mental institution but, on insistence of her mother was shortly after discharged against medical advice. At home, more than ever controlled and protected, she developed her first manic reaction. This apparently was not only an immature attempt at repairing the damage done to Anne's ego but was, besides, a rebellion against her parental home which more than ever was antagonistic to her emotional strivings.

In 1941 Anne was hospitalized in Hudson River State Hospital. On admission, she stated that she had left her home and gone to live in hotels because she wanted to become self-assertive. She said that she had been dominated all her life and, for once, wanted to do what she pleased. She also related a dream which scared her, as she slapped her mother's face in it. Anne recovered rapidly and left the same year in custody of her mother. At home she resumed social activities, but, as her father felt that the tension of working

might still be too great, she delayed consistently to seek employment, although she was rather unhappy about it. Thus, shortly before expiration of her year of convalescent care, Anne had a second manic reaction and was returned to the hospital.

In 1942, soon after admission, Anne's father died; and in the hospital record, it was noted: "That despite the fact that Anne was much attached to her father no adverse reaction was observed." Therefore, and in order to help her mother, Anne left again on convalescent care in custody of her mother. On leaving the hospital she remarked that this time she was feeling much better than on her last parole. At home she found her mother gravely ill and immediately began to manage the household efficiently. When she was visited once by a social worker, he noted: "The mother lost her peppy, bright and cheerful attitude. Anne, however, had gained weight and appeared to be enjoying a comfortable period." Obviously the setting was favorable for both Anne's desire for self-determination and for her still-existing need for security, which was offered by the passive presence of her mother. However, a few months later, the mother died and though there was no immediate adverse reaction, Anne fell gradually into a depression. As at her first depression, Anne had lost the basis for emotional gratification and as yet was not mature enough to deal with a transitory emotional vacuum. But that Anne's maturation had advanced since her first depression was indicated by the fact that this time she returned spontaneously to the security of the hospital.

In 1943 she was readmitted on a voluntary status. At the hospital she was well adjusted from the very beginning, but despite that, her discharge was delayed until 1946, as, judging by her past conduct, it was felt that she emotionally was not stable enough to leave on her own, and there was nobody who wanted to take her out. In 1946 a girlfriend was found who not only did accept the responsibility for her but also offered to share her home with Anne provided she could support herself. This was an optimal setting to begin with. Anne has done very well ever since. She has been married for the last two years.

The course of this case demonstrates that while an environment antagonistic to normal human strivings does not necessarily precipitate a psychotic reaction, it can reactivate a reaction as long as it is not eliminated and replaced by an environment more compatible with the individual's emotional strivings.

Summary and Conclusion

From a larger group of Hudson River State Hospital patients, three representative cases were selected for discussion of the value of environment manipulation in a state hospital.

Despite marked improvement or recovery, each of these patients relapsed as soon and as often as they were returned to their original settings. It is pointed out in general that besides hereditary disposition and past background, the patients' current interpersonal relationships are responsible factors in precipitating the recurrence of mental reactions.

Specifically, it was demonstrated in each of these cases that a relapse was precipitated either by the patient's own irreversible emotional antagonism toward his environment, or vice versa by an unmodified antagonism of the patient's environment toward his emotional strivings. Any attempt at modifying these patients' environments was extremely difficult, as rather resistant and incorrigible attitudes were encountered. In the later courses of these cases, however, relapses were prevented temporarily or even entirely, any time the patient moved to a different setting or the original setting modified itself by chance.

Judging from the course of these three representative samples of a larger group, it is felt that environmental manipulation, although difficult, is indicated in at least a selected number of cases.

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PROBLEMS OF ADMINISTRATIVE PSYCHOTHERAPY IN MENTAL HOSPITALS

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There is generally-increasing investigation of the therapeutic role of administration in a psychiatric hospital treatment program. This discussion will describe some aspects and problems of the organization and function of administration when it aims to serve as a therapeutic tool.

The collected thoughts formulated in this article are based on observations made in the course of treatment of many psychotics and some severe neurotics in a small mental hospital (Chestnut Lodge, Rockville, Md.). Each of this hospital's patients receives individual, psychoanalytically-oriented, psychotherapy. In addition, each patient has a separate administrative physician. The problems of both the individual and administrative therapy are given analytic consideration. The writer will try to demonstrate, by means of some examples, what may happen in a psychoanalytically-oriented hospital when there is this organizational separation of administrative therapy and psychotherapy. The major emphasis will be on the strength and weakness which may arise from a number of people participating in a treatment program. The observations may have applicability to other mental hospitals even if of different size and function.

Patient-care consists of attention to physical needs and of examination—by the patient and his individual therapist—of the interpersonal factors leading to emotional distress. In pursuing this objective, the hospital attempts to provide opportunity for growth and adjustment and attempts to diminish the stimuli which might reinforce the illness. The hospital may serve as an opportune place for a patient to recall and re-evaluate previous experiences and to integrate the past with the present and future. The individual therapist alone cannot accomplish this objective. The good experiences of individual therapy need to be reinforced through repetition in other daily experiences.

The administrative service has the function of structuring the environment to serve: first, as a positive therapeutic agent in itself and, second, as a stimulus to the patient's work with his individual therapist. These goals can be further defined as: first, nur-

turing the dependent needs and fostering the personality growth of the patient; second, through recognition of the total problem, setting reality limits; and, third, structuring the environment so as to relieve the anxiety generated in the psychotherapy rather than forcing the psychotherapy to relieve the anxiety generated on the ward. By nurturing dependent needs the writer means: first, offering the patient relief from the burden of managing all aspects of his daily living; second, having recognition of his wants, responding to them, and if possible anticipating them; and, third, giving the patient an opportunity to express wishes which are truly his own. This last may be in contrast to his previous life experience in which he may have been able only to express what he felt was wished of him by his parents or their surrogates.

By the realistic imposition of limitations, is meant a recognition of the capacities of the patient to assume obligations in the care of himself and the permitting of free exercise of those capacities without over- or under-restricting him. In this over-all process, the hospital needs to be prepared to meet not only the needs of the patient, but in part those of his family and of the hospital personnel as well. This involves a simultaneous study of the old environment, the family, and the new environment, the hospital.

The major burden of the complex job of administrative psychotherapy falls upon the physician administrator, who is the administrative therapist. To facilitate the development of the administrative aspect of the total therapeutic program the administrator needs to integrate the activities of his administrative team—the nurses, aides, social workers, occupational and recreational therapists. The strength of the administration may lie in this team, but so also may its weakness. A number of persons engaged in observing, reporting, and evaluating events surrounding a patient's past and present living, plus the tendency of members of a group to check the erratic decisions of any one member, may make for strength in formulating and executing plans. At the same time, the very numbers of these people, the variety of approaches, and the possible fundamentally different points of view may weaken the therapeutic effectiveness. Since anxiety is a disrupting force, an already bewildered patient may become more bewildered in the face of real or imagined differences of opinion among highly important people.

Anxiety can be diminished within the administrative team, through all members having a common understanding of the problem at hand and their roles in relation to it. The effectiveness of the team is tied to the speed and accuracy with which it can exchange ideas and disseminate information through the written record, personal conference, or group conference. The transmission of ideas must be circular rather than linear, since insufficient information, or information passing in but one direction, can only lead to personally-motivated decisions rather than total planning. There may be differences of interpretation of a patient's behavior and responses, so that a therapist interpreting one way may encourage therapeutic investigation along lines which are incompatible with the activity limitations imposed by the administrator who is interpreting differently. Problems of competitiveness, sibling rivalry, and resentment of authority among all members of the staff can all too easily interfere with good over-all treatment.

Let us consider some examples of the strengths of administrative therapy when it is functioning as a co-ordinated team.

A patient with a long-documented inability to manage his life on the outside came into Chestnut Lodge and was put on a moderately restricted activity regime. Had it not been for the pre-admission data, the patient might well have convinced the staff of his ability to handle most privileges. With the advance knowledge and the team alerted, early evidences in the hospital of poor handling of life situations resulted rapidly in increased restrictions. The patient expressed great rage which the therapist then put to good use; first, because the patient then became consciously aware for the first time of such a feeling within himself; and, second, because it led the patient to recall similar feelings toward his most arbitrary, authoritarian mother.

For another example, a patient persistently attempted to ward off contact between the hospital and his family. This was reaching a crucial stage because the family was expressing inability to maintain treatment financially. The administrative team, in collaboration with the analyst, believed that the isolation from the family was harmful to treatment, and, over the patient's protests, the family was brought in. In conversations among administrator, social worker, and mother it was learned that funds could be produced to keep the patient in treatment. Further, the family members were grateful to the worker because she had finally enabled them

to express their side, their doubts and concerns. The patient learned from this experience that others could have contact with both him and his family without becoming prejudiced against one or the other. This made for further progress in psychotherapy and for the patient's use of the whole hospital as a therapeutic agent. In this case, it was only through collaboration of therapist, administrator, and social worker that the need and the timing could be planned and the project satisfactorily worked out. Each had contributed his part, his understanding, and was prepared to handle the responses.

Another case is that of a severely paranoid person trying to live as an outpatient. The therapist was unable to explore the patient's dependency and hostility toward women. The administration staff, primarily the social worker, saw the patient extensively and was able to offer a nonverbalized understanding and acceptance of the patient's dependent needs, along with support in his striving for independence from his mother. At the same time, administrator and social worker worked with the family members to help them see and respond to the patient's needs. In this process data were brought back to the therapist from the patient and his family, which assisted the exploration with the patient of his loneliness, his dependent feelings, and his subsequent hostilities. Had there not been team support, it is unlikely that the rigid defenses could have been penetrated or at least it would have taken much more time to penetrate them.

How do these general principles apply to the nursing part of administrative therapy? The nurse and aide are in the position of having more contact with the patient than any other members of the team. But it is difficult to live with 10 to 12 psychotic patients for eight hours a day, five days a week. By virtue of the closeness of contact and frequency of contact, in order to remain objective with the patient, the nurse needs the full support of the entire team, full information as to what is going on, information about the dynamics, but not the actual contents of the psychotherapeutic procedure, and an opportunity for clarifying differences of opinion with the team.

The importance of an available channel for expression for the personnel who deal with disturbed patients is demonstrated in the case of a nurse who found herself becoming distressed and unable to participate in the necessary tube-feeding of a patient.

The nurse's distress was unrelated to the patient's objective need, since this was medically indicated. The tube-feeding scene was re-enacted by the nurse at the personnel psychodrama seminar; and, through this help, she was able to relate her present personal distress with her earlier life experiences, and she was further able to gain some understanding of the patient's resistance to eating. The nurse learned several basic facts from this experience: that she could become considerably involved with a patient because of her own personality problems; that these problems could be worked out with those about her; that she need not feel humiliated for having had the tube-feeding problem and, last, that she could return to the patient secure in her self-respect and her new ideas. Because of her diminished personal anxiety, the nurse could now approach the feeding problem more objectively. The patient responded to the new approach and tube-feeding ceased as of that day.

The last example of good administrative handling refers to a serious problem of stereotypy. Over a long period, it was well documented that a patient's basic defenses against anxiety were a stereotyped refusal of food and a verbalized desire to run from the hospital. Every attempt at analyzing this was countered by vigorous repetition of the stereotypies. Nurses, aides, administrator, therapist and patient collaborated and decided on the following platform. "You need care; you are underweight and need food; since you cannot handle the responsibility of feeding yourself in any way, we will feed you by tube twice a day until you gain 20 pounds; then we will renew discussions of other ways of your taking adequate nourishment. You need care; you cannot get it if you run away; we will stop you from running; if you leave we will bring you back; when you are ready to handle this problem by yourself, we will talk over further plans with you." Although the patient gave lip service to fighting this program, it seemed equally clear that he wanted it. He kept testing to make sure the program would not be changed. In this setting, the patient gradually assumed and carried through the responsibility of taking adequate nourishment and of not fleeing the hospital. Tube feedings are no longer necessary, and the patient has "unaccompanied privileges" for several hours each day. Knowing that his basic needs will be answered by the hospital, if not by himself, the patient has been able to examine with the therapist the interpersonal factors behind

the anxiety. It is the feeling of all concerned that it was primarily the intelligent sharing in the responsibility for the patient and a consistent 24-hour-a-day program that made the improvement possible.

It was pointed out earlier that although there may be strength in a team, there may also be weakness because of diverse points of view or interpretation.

Examples of weakness stemming from diversity frequently present themselves about the question of privileges. A request to leave the hospital may stem from a lucid moment in a psychosis at which time the patient feels well enough to leave. It may also stem from a patient's need to test the environment repeatedly to see if there is awareness of his needs and problems. If a patient senses that one of the team, who is important to him, considers him well, the patient may wish to please that person by echoing a request for discharge. Occasionally the request for increased privileges or premature discharge stems from the ambivalent or displaced feelings of administrator or therapist which are directed toward the patient. A patient may well be discharged too early if either the therapist or the administrator is unaware of his own ambivalence, his competitiveness with the other or his insecurity regarding his judgment. This state can only occur, however, if the team is not "talking" and bringing pertinent data to the fore. These situations are not unusual or always to be looked upon as pathological occurrences. They are but one form of an anxiety-produced disruption. This disruption does not occur when all members of the team meet at regular conferences, for, in the conference situation, someone is bound to offer a dissenting opinion or catch the shifting away from the facts.

Recently a patient received full hospital and town privileges before the decision was clarified in general staff. The therapist complained that he did not understand the administrator; the administrator insisted this was a problem purely between himself and the therapist, and refused general staff help. The patient's solution to this dilemma was running away, not because he was unable to handle some of his freedom, but because, as he said later, "I was scared. It was too much at one time." It took many hours of senior staff time to clarify the issues involved in the difference between therapist and administrator, this difference being expressed

symptomatically as a shift away from basic hospital policy and function.

Another striking example of the team function and the central problem of communication was demonstrated in the following way. A patient, who had been personally interviewed some time previously, was hurriedly admitted in response to a call from frantic parents. This seemed, to part of the staff, to be contrary to the agreement established between the hospital and the patient, that is, that the patient would admit himself if ambulatory therapy was unsuccessful. The disagreement was further strengthened by the father's reluctance to give adequate data and his rapid disappearance from the scene. As a result some administrators accepted at face value the patient's story of being "railroaded." This administrative resentment toward the hospital was overtly expressed, and an attitude was formulated toward the patient of, "We do not think you are as sick as they say you are." This was accompanied by a lenient administrative policy consisting of a number of privileges and a move to a less disturbed ward. Within a short time the patient showed more bizarre behavior and had to be returned to the floor for more disturbed patients, with restrictions in activity. It was as if the patient had to take the problem of being considered seriously ill into his own hands and had to force the environment to recognize his needs. On return to the floor for the more disturbed, he became more comfortable and was able to engage more fruitfully in his therapy. It was not until several weeks after admission that the pre-admission disturbances could be clarified, this as a result of the social worker allaying the anxieties of the family so that the mother could pour forth all the heartbreaking experiences and frustrations leading to a forcing of hospitalization.

The writer is sure this example is all too common in hospitals, but he cites it because of the three issues it introduces. First, there is a need to recognize that a team member may identify with a patient as a result of his own anxiety. Second, there is a need to have all team members active in getting and disseminating data early because of the disaster which can result to a patient if this is not done. And third, there is a need to clarify any difference of opinion among the staff prior to discussing it with the patient.

The need to clarify a situation before embroiling a patient in it can be seen when a patient begins to manifest strong negative or

positive transference feelings toward the therapist, but does so by projecting them onto the administrator or the hospital in general. If the therapist, because of his own feelings and interpretations, tacitly or explicitly agrees with the patient in his distortion of the hospital, a block will result that a third party will have to remove. It may very well fall to the administration to guide the patient back to examining this situation with the therapist as the patient's problem. This cannot be done by simply pointing out to the patient that he is in error in his thinking. A joint conference of therapist and administrative team can perhaps work out the dynamics and differences and set aright the total approach to the problem. The chance of success can be reinforced by continuing to answer the patient's needs throughout the period of discussion.

The lack of adequate discussion for the airing of differences may occasionally result in one of the team personnel (be it nurse, doctor, or other) suddenly leaving the institution in a great flurry of anger and resentment, which actually has as its basis an unsolved personal conflict. This can be avoided if the institution accepts, and provides for, adequate communication and self-expression.

In summary, it should be stressed that although there is great strength in numbers, there may also be weakness in those numbers stemming from diversity of opinion. This weakness implies a lack of understanding of differences of opinion; it does not imply a need for uniformity of thinking. This weakness can only be overcome, first, if there is adequate recognition of the responsibility and authority of the various persons concerned; and, second, if the hospital offers the adequate channels and the necessary time for expression and clarification of those diversities to the point of mutual understanding and collaborative effort.

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THE SOCIO-ECONOMIC TRAUMA

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There exists an incongruity between that which patients tell us about their life experiences and the record of what they tell in case histories as they are published and evaluated.

Many patients who have experienced poverty and economic hardship in early life attribute to this economic insecurity a great influence on their psychological development. Yet we find little attention given to this circumstance in psychiatric textbooks and articles.

Some examples will demonstrate this point: To a depressed schizophrenic patient the question was put: "Did you ever do something very bad?" Without a moment's hesitation, he answered in a whimpering tone: "I was ashamed of my mother. We were so poor. I used to hide when I saw her coming when I was playing in the street."

A psychopathic girl addicted to marijuana was asked in hypnosis to remember a happy moment in her life. She reported: "We were very poor and I found a dollar in front of our house. I gave it to my mother and she looked at me with such a happy smile."

When patients complain about their early shyness, lack of energy and so on, and when they are asked, "What made you feel that way?" the answer is often, "Maybe it was our poverty," or, "I felt so badly about our way of living."

Many patients mention their poverty more casually. Apparently they are under the impression that in psychiatric treatment economic insecurity is not an important factor to discuss. In free associations and in autobiographies, however, the impact of economic hardship is brought out over and again.

Sometimes it is not the poverty itself that impressed the patients, but it is rather what the poverty did to the feelings of the parents and to the atmosphere in the home. If the parents feel frustrated, the children may become hopeless and helpless. They may lose confidence in their parents, they may rebel, or they may withdraw from their surroundings.

All these feelings may be extended to society in general and may lead to different forms of social maladjustment. The parents' outlook on the problems of life and the child's relationship with

the home is, in this field as much as in other respects, of great importance for the development of the child's personality.

Paul Schilder[1] wrote: "The unit in which the neurosis is constructed resides primarily in the family and only secondarily in the social structure. However, the social structure as such has already exerted its influence in building up the family." He remarked, however, that there was not one trend in which there was a fundamental difference in the symptomatology in two groups of different economic status.

It has been generally accepted that childhood is a period of great vulnerability in the psychological field. The study of the traumata experienced during this period has focused on such occurrences as: lack of love, broken home, parental overprotection and neglect, sibling rivalry, difficulties in school, etc. Usually the economic status is mentioned, too, but rarely is the impact of this factor explored more extensively or deeply.

Cyril Burt,[2] writing about delinquent children, exposes some of the ways in which economic traumata may affect children:

"Less shocking to the casual caller, but often far more serious in its ultimate effects, are the ceaseless friction and recurrent irritation which, even among families the most forbearing and patient, can hardly be prevented while a number of individuals differing widely in wants and in pursuits according to their age and station are kept jostling, every day and all day long, in the closest personal proximity within the four narrow walls of an overpacked apartment.

"One constantly recurring situation develops in the poorer home. The underfed, overworked mother, with a large and boisterous family, short of money, short of space, and short of time, is often physically weak and mentally slow; not overcompetent, as a rule in household management; and sometimes harassed to the verge of nervous breakdown by the twofold strain of keeping her spirited youngsters in hand, and of making both ends meet."

W. L. Neustatter,[3] after comparing children from well-to-do families with others from poor families, finds that poor social conditions are not, in themselves, a direct determinant of "nervousness" in children. He finds a statistically significant relationship between the presence of a worrying disposition in the parents and the presence of anxiety in the children, irrespective of class. He states, that indirectly at times, social circumstances affected chil-

dren through the parents, but surprisingly little, and generally when parents were already "nervously predisposed." He notes that in adults of an anxious disposition, economic conditions can produce severe reactive states, anxiety, depression and unhappiness.

With respect to adults, R. N. Tronchin-James[4] writes in the same vein, that "anxiety patients have fear of the future and worry over money, which so often becomes a focus for their anxiety."

It is possible that these conflicting points of view are due to the circumstance that it takes time before the effect of socio-economic insecurity in youth combines with other factors and thereby produces some form of mental maladjustment.

Leo Kanner[5] remarks that there are difficulties that are more or less closely associated with the family's financial status and that problem children come from all social and economic strata.

It is true that not only the extreme grades of poverty constitute traumata to the child. The relative status of the family may be as important. A family that is unable to keep up with the Joneses may impress a child with a feeling of inferiority out of proportion to its actual deprivation. Even in the well-to-do classes, a child may be ashamed if its relatives are better off than its own family.

A somewhat unusual trauma was experienced in three cases described by Sandor Ferenczi[6] "in whom social advancement of the family at a time when the patients were young children proved a most significant aetiological factor." In their adult lives, there still remained with these patients a feeling of their social inferiority caused by their early poverty. At the latent period, they came to live under refined conditions to which they were entirely unaccustomed. Eventually they came for psychiatric treatment because of sexual impotence and *tic convulsif*.

Another problem arises if the parents have been able to climb the social ladder and demand that the children equal them in their rise in society or do even better. Under such circumstances the child may be burdened by too much responsibility or may be frightened out of proportion by the danger of losing its wealth.

The feeling of competition that pervades life is more than many children and certainly many grown-ups can take. Often children put as their goal in life to become rich and famous, even though this goal is as far beyond their grasp as are the stars in the sky. Grown-up patients tell of their unhappiness because they compare

their early hopes with their ultimate attainments. Bragging children, with psychopathic traits of lying, stealing, playing hookey, are often the product of the frustration which they have noticed in their parents.

Here follow parts of an autobiography from a woman with a character neurosis:

"From the time I was three to five, some of the dominant things I remember are that I received a lot of affection from my grandparents and my parents.

"The pattern for my social development was set in the period up to the time I was five and a half. We lived behind the candy store in a residential neighborhood and already at that time I wished we lived in a one-family house and had a garden and that I had a room of my own. Incidentally I slept in a double bed with my parents. I do not recall being aware of any sexual relations between my parents. I hated sleeping with them because I wanted privacy. I loved the home of a little girl with whom I played and I still remember exactly how her room was furnished. I remember that at that time I admired her clothes and toys, that I was aware that she had money and that I did not and that I wished I could be like her. When I was in a group at that time I was a follower. When I was in a group I would become very close to another child if the child was older or more aggressive. I would be dominated and bullied and be afraid and unhappy. I was very shy.

"When I was five we sold the candy store and lived a block away above another store. For almost a year my father looked for a new business and during that year I felt my family had achieved more status because my father did not work Sundays and because we did not live behind the store.

"Before I was six, my father bought a house. It consisted of a candy store, rooms in the back of it and an apartment above. The neighborhood was definitely middle class and socially and economically on a higher level than the neighborhood in which we had been living. Inevitably the conflicts I had about the status of my family in the community were to become worse. As before, we lived behind the store.

"My brothers and my mother used to nag my father and I was very sorry for him. I also often felt sorry for my mother. The kind of pity I felt for both my parents was very close to anxiety.

"Until I was 10, I was very ashamed of our status in the neighborhood and I hated the fact that we did not have a one-family house or at least an apartment in a two-family house. I daydreamed a great deal of the time, wishing that I had a different home.

"I was quite bright in school and also quiet and obedient. The class I was in always seemed divided into two groups: those who clustered around a natural leader who was pretty, in comfortable circumstances and already popular with the boys. There was always another group, that was smaller and less aggressive. . . . Often Iused to daydream that the leader of the first group was my best friend and that I was the co-leader of the dominant group. My relationship with those children who were my friends was superficial because I would never let them know what my home was really like. To make up for the inadequacies of my family, I invented stories of the wealth of my relatives, I told them that I had a doll that could walk and talk, etc.

"From the time I was 10 to 13, the cramped quarters of our home became increasingly oppressive. I used to pick out houses in the neighborhood and pretend that we lived there. At this age, I was not popular with boys. My lack of popularity was certainly related to the fact that I was shy and this streak of feeling inferior to other girls is still a part of me.

"Finally when I was about 14 and had recently entered high school, we moved out of our cramped apartment. The years following this were, in many ways, the happiest years I had had up to that time. I made many friends in school who did not know that once my father had had a candy store. My problem, however, was that I did not have as much money, clothes, etc., as my friends had.

"My mother had always frightened me about our not having money. For years I had wanted to go to camp. My mother always said that I could not afford to go. Finally when I was 14, I was sent. It was obvious that mother did not give me enough clothes. Her letters told me how they had had to borrow money to send me, etc. My grandparents sent me a dollar as spending money and I was so shocked by how poor we were that I returned it."

In this autobiography, several of the factors mentioned in the foregoing discussion are clearly expressed.

Without apparent reason, one or the other deprivation impresses some patients more than others. An 18-year-old boy who suffers

from shyness and inability to express himself remembers about his early youth:

"I had no toys. Other boys had beautiful big toys. I used to go to play at another boy's home. I was ashamed of the way I was dressed, my sweater was too small, the sleeves too short. I wore faded short pants and old shoes. I was shy, ashamed of myself."

The factor of rivalry with friends as to the possession of toys is brought up by several patients and seems to express the general feeling of inferiority under these circumstances. Some grown-up patients recall how ashamed they were when they were sent to accept worn clothes as a gift.

Others were continually hurt when their parents themselves used to compare their homes with those of more successful relatives and when they gave the children the feeling that they should make extraordinary efforts to make up for this deficiency. This was felt as too great a burden for a child, who would withdraw or give up the struggle. Such children lose confidence, not only in their parents, but also in themselves, because, coming from such an environment, they feel marked from the beginning.

If the mother holds the father responsible for the fact that he is a bad provider, the feelings conflicting between love and contempt for the father are even more harmful. If the father expresses his resentment, the ensuing quarrel is most painful to the children, who become more and more bewildered.

A situation of this type is manifest in a diary and autobiography of a girl who, in later years, was treated for shyness, withdrawal and fear of sex relations:

"I need school supplies. I asked Dad for money. He was mad. I believe someday he will make Mom so mad, she could actually kill him. Although I hate to say so.

"I am going to get good shoes. My friends respect me.

"Our lights were put out. Dad found someone to pay the electric bill.

"The investigator was there from some Relief Bureau. I do not know why I hold contempt for Dad. It was nasty to write that I hate him. Why must mother be unhappy? The fortune teller said to mother that one of her children was selfish. I guess I am doomed.

"The investigator was here. Everybody knows him. What shall we do! We are all disgusted with Dad and life. I don't know why. . . ."

Pity for the parents is usually more than a child can stand. Mixed with pity, is a feeling of responsibility too heavy for the child's age and the child responds with worries beyond its years and its powers.

The effect is much the same when the parents are not pitied but are held responsible for the situation. It is not rare to hear in later years that the family had a difficult time financially and that the child resented this and that the mother was blamed for what was felt as lack of affection since she was too busy to spend leisure time with the children.

Relative or absolute poverty makes its impact felt either in a direct or in an indirect way. Such factors as malnutrition, bad housing, sickness and others might be mentioned here in passing. It is well known that these are the causes of many psychological disturbances. Living with unhappy, frustrated parents the child grows up in an atmosphere of depression and gloom and it will respond according to its personality. It will try to escape or to "get even." It will learn to adjust too readily to frustration, or to fight too quickly against anything that seems "hostile." Often one hears from an adult that he "hated" his father because, he was so stingy or did not allow him to continue his school education.

The list of the hardships experienced through economic insecurity is long and is by no means exhausted by what has been mentioned thus far; the consequences are fateful and not only for childhood. They extend through the rest of life.

Some clinical syndromes are particularly related to this form of early stress. As examples of these syndromes, one might mention such character disturbances as:

Lack of ambition and drive. Withdrawal.
Resentment against people in general.
Inability to spend money. Stinginess.
Squandering. Compulsion to buy expensive clothes.
Inability to form social relationships with consequent failure in profession.
Sex problems.
Difficulties in deciding on marriage or on the choice of a marriage partner.

Many of the patients with lack of initiative or with painful shyness, when asked when it started, point to their original feelings of shame and frustration:

"Whenever I became a member of a group, I soon gave them up. I was afraid to become involved so much that I would have to invite people to my home. Even now I do not invite people. My home is not as nice as someone else's.

"In high school a teacher gave me attention, was encouraging. In later years I avoided him. Was I ashamed of my poverty? My teacher represented the better side of life, my parents the conflicting side. If I became a teacher that would give status to my parents. Because I was ashamed I stayed home, reading instead of making relations with people. At the age of 14 to 16, I began to feel a wall between me and people. It was in the second year of college. It did not bother me at the time. Lately it bothers me. Maybe it started earlier in high school."

Another patient who never went through real deprivation expressed the same feelings in the following way: "I never felt proud of my parents. I sooner would go in hiding than to appear with them in public. I was always sensitive about my father being in a grocery store. I could not think of having my mother come to school; she seemed on another level than my friends' mothers. She never dressed well. I always had the idea that it was tough to make a living in the world. In the presence of strangers, I always was at a loss for words. There was a gulf between us. Everything new and different in my routine makes me nervous—such as talking to a stranger over the telephone."

This shyness and inability to stand up for themselves often has fateful consequences. Often such persons are too "flustered" even for menial jobs, and they have to change jobs frequently. This, in turn, makes them more insecure, and finally they give up making any effort, they start coming late, or feel too sick to go to work. They pass their time daydreaming, withdraw from people, take an autistic attitude. Here one finds cases of pseudo-schizophrenia which respond well to treatment.

Stinginess and fear of losing what economic security has been gained are often related to early insecurity by the patients themselves:

"As a young boy I suffered about looking shabby. I asked my mother for money. She said that I demanded more than she could

give. Later I became indifferent about clothing. I had given up the struggle for life. I let my beard grow, I became lousy. At a certain period of my life I wanted to be blind, it seemed sweet. It meant that I wanted to be taken care of. At that time, as now, I was arrogant, demanding. Between nine and 13, I had no clothes, I was poor. I hated the neighborhood, people disliked me. I always was selfish. I wanted money for the movies. A friend took me to the movies and gave me pennies. He called me a beggar. I still feel hurt remembering that. Now to give my child a feeling of security I let pennies lie around."

Another expresses his feelings this way:

"When I was young we were very poor. There was no encouragement for self-expression, such as music. We were unable to afford things. Still now I have a fear of poverty; therefore I cannot enjoy what I have. I do not like to buy things. There is always the fear that there will not be enough for tomorrow."

Early shyness, shame and money consciousness often have a detrimental effect on the choice of a marriage partner and on the decision for marriage itself. Interpersonal relationships may be so defective that there is no attempt at normal sex relations, and refuge into sex perversions is taken. When sex relations are tried, impotence sometimes is the result.

In other cases, after a desirable sex partner has been found, the relationship soon becomes disturbed by ambivalence and anxiety, and the only way out is to break it off. Here one finds persons who repeatedly go into an engagement to be married and who withdraw when the date for marriage has to be fixed. When, however, an engagement of this pattern comes to actual marriage, problems may soon arise, because a pattern has developed of introversion and withdrawal. Already, before marriage, persons with such a pattern have been too insecure to accept responsibilities. Therefore, they fail altogether in marriage and disappoint their partners who did not suspect these shortcomings. Whether they blame themselves or their marriage partners for the ensuing arguments, the relationships are equally disturbed, with the well-known consequences for the children.

Many of these patients dare enter marriage only if the partner can provide them with sufficient funds or a secure position. This restriction in the choice of a partner leads to unhappy conse-

quences if a person continues an emotional bond with a person loved in the premarital period and rationalizes his feelings of dissatisfaction through comparisons.

For these persons who are overly conscious of the importance of social prestige and economic security, the choice of a profession is as much restricted as is the choice of a marriage partner.

Here follow a few utterances of patients on this subject:

"When I brought Mary home, my attitude to my father changed. I was not so much ashamed anymore. It was sort of consoling that her father too was in a grocery store. I always had the idea that it is tough to make a living in this world. They said I never learned to work, I was soft. I always felt that my father had to work too hard. I wanted something better for myself.

"I was always ashamed of work; business seemed more honorable. I want a soft life. I want to sleep all the time.

"As a child, I used to cry walking around, seeing people having rosy Christmas trees. Between the ages of nine and 13, I had no clothes, I was poor. I have always felt that middle class meant safety, but I am not acceptable to middle class. I need them. I want to have a home for which I am not ashamed. Money is a sensitive spot to me. My wife has not been able to buy clothes for a long time. She earns money and she gives it to me."

Another patient who spends most of the family income for his own needs resents the fact that his wife rarely wears jewelry.

One patient remarked on the question as to what was the best time in his life:

"In the country on the farm. I had to work only if I wanted, it was play. I always was lonely. I wanted to love someone, but there was no one. I did not earn enough. I did not know how to approach the girls I liked. When I met Claire I did not want to commit myself. I had money in mind. Would I earn enough? I wanted an easy life. There was the example of what my brother had gone through."

Many patients have memories of the following type:

"During my last year in high school, I had to decide what I was going to do afterwards. My great love was science and I would have given anything to be able to study medicine. . . But I felt that I could not afford it." . . . "Finding a job was no easy matter. I looked for the following 14 months." . . . "I decided to get married. My mother did not like it. Her family might disapprove of

this poor man. I felt guilty because my mother had to give money. . . ."

It seems superfluous to complete this list of how patients have reacted to the frustration, the shame, the guilt feelings resulting from economic insecurity, how these have influenced their lives in vital points.

The question comes up: Why have psychiatric writings pushed this factor into the background?

Only in connection with juvenile delinquency and addiction is the factor of bad housing and poverty mentioned regularly. Even then this is done usually in a rather general way. Rarely is due evaluation of the patients' specific feelings and reactions given. Yet it is often helpful to patients to discuss this factor more fully. It is beneficial and reassuring if they realize that everyday factors such as competition, poverty, economic insecurity, have made them lacking in self-confidence, withdrawn, frustrated, etc.

These are factors of which they have been aware in general. They have failed to apply them to their own particular cases. Insight into what they have been and are up against will often force them to face reality better. Students of psychiatry will make better psychiatrists if the textbooks give more attention to these factors. At the same time, it should be remembered that "no psychiatrist will proclaim that ALL our human woes and errant behavior are dependent upon a faulty economic social system"—as Lawson G. Lowrey[7] puts it.

The next task will be to determine:

1. What specific consequences this socio-economic trauma has.
2. Whether the effect is different, depending upon the time of life in which it strikes.
3. How the factor of socio-economic insecurity combines with other factors such as the influence of disturbed parents and siblings, physical sickness, undernourishment, constitutional predispositions to mental sickness, the status of race minority, etc.

Summary

Socio-economic status has an important and manifold influence on mental adjustment.

The competition necessary for socio-economic survival is too heavy a strain for many personalities.

Shame over inferior social status is often the cause of such symptoms as withdrawal and introversion.

Based on early economic insecurity, disturbances of interpersonal relationship may develop and take such forms as sexual maladjustment, marital and professional maladjustment.

Originating in early economic insecurity, we find character disturbances such as general hostility, suspiciousness, submissiveness, dependent needs, lack of energy, laziness, shyness, disturbed relationship to money, etc.

For adjustment to reality, a clear insight into these factors is helpful for psychiatric patients.

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REVIEW OF LEGISLATION FOR THE YEAR 1953

BY E. DAVID WILEY, LL.B.

The members of the 176th session of the New York State Legislature introduced 6,157 bills, of which 1,212 were passed and sent to the governor. Of the bills sent to the governor, 879 became law, and the governor vetoed 333. The 1953 session was not marked by any outstanding legislative programs.

The Department of Mental Hygiene directly sponsored nine bills. Two of special importance to the department and the institutions were: (1) amendments of Sections 85 and 134-a of the Mental Hygiene Law relating to the commitment of dangerous patients to correction institutions, (2) extensive revisions of the Code of Criminal Procedure relating to mental examinations and commitment of defendants in criminal actions. In addition to the bills directly sponsored by the department, there were seven bills introduced at the 1953 session that became law, and that were of such special interest to the department that it either participated in the drafting of the legislation or gave its approval to it.

Consistent with previous legislative reviews, the laws here reviewed will be grouped under "Appropriations," "Mental Hygiene" and "Related Statutes."

Appropriations

The 1953 session of the legislature, in enacting a record budget for the state, allocated for the support and operation of the Department of Mental Hygiene, its institutions and programs, including capital projects, equipment, and rehabilitation, a total of approximately $163,000,000 under Chapters 20, 23, and 276. This is the largest appropriation for any department of the state. This sum includes in round figures: $31,500,000 for new construction, an estimated $10,000,000 for emergency compensation, $1,200,000 for equipment, $500,000 for rehabilitation projects, $700,000 for the state hospital retirement system and $100,000 for research on alcoholism. The remaining $119,000,000 appropriated is for operating expenses of the department and its institutions.

Direct appropriations to the department showed a net decrease from the previous year of $12,627,370. The appropriation of $78,-

206,202 for personal service is an increase of $3,370,517 over the previous year. That of $40,848,011 for maintenance and operation is a decrease of $3,279,039 from the previous year. The continued and increased emphasis by the administration and the law-makers upon prevention and research may be noted in appropriations to the Mental Health Commission of $1,036,755, an increase of $199,555 over the previous year, new items for research at Rockland State Hospital $63,670, and research at Manhattan State Hospital $9,120; and the continued support of research projects at New York State Psychiatric Institute, Creedmoor State Hospital, Letchworth Village, Craig Colony, and Sing Sing Prison.

The department's share in the Capital Construction Fund for Rehabilitation under Chapter 276, Part 10, is $500,000, exceeding this item in the 1952 appropriation by $116,000. Allotted to the department for equipment from this fund is $1,355,985. Appropriations for the department for new construction total $31,514,500 under Chapter 23, which is $13,483,042 less than the appropriations for this purpose in 1952. This sum is to include additional patient accommodations at Kings Park, Marcy, Middletown and Manhattan state hospitals, providing a total of 1,500 additional beds.

Provision also is made for essential utility buildings required by the expansion of patient accommodations at Central Islip, Creedmoor and Middletown. The appropriation made a year ago for "acquisition of a site and preparation of plans, etc., for a new state hospital in New York City" was amended in the original budget to make it available for "additional patients' accommodations in the metropolitan area." This would permit it to be used for one or more types of institutions.

In addition to the specific projects for institutions, the budget contains $500,000 for new staff accommodations, $200,000 for the conversion of employee quarters to patients' accommodations, and $500,000 for equipment for new facilities. This year's appropriations include funds for equipment for existing facilities in the amount of $1,266,000, an increase over the previous year of $266,000.

Mental Hygiene

Chapter 95 amends Section 19 of the Mental Hygiene Law, in relation to qualifications of certified examiners, to make any duly

licensed physician eligible to become a certified examiner upon complying with the other requirements of the law.

Chapter 117 of the Laws of 1953 amends Section 26 of the Mental Hygiene Law in relation to the powers of the commissioner by deleting the last sentence in that section which denied to the commissioner the authority to delegate the power of appointment of officers and employees.

Chapter 149 amends Section 34, Subdivision 14, of the Mental Hygiene Law in relation to the powers of directors of institutions. The value of funds or other personal property of a patient the director may receive without the appointment of a committee is increased from $500 to $1,000. The new law also provides that funds belonging to a patient, received by the director pursuant to law, shall be received by him in his official capacity and such receipt shall be deemed an exercise or performance by him of a power and duty duly conferred by Section 34.

Chapter 410 repeals Section 46 of the Mental Hygiene Law and enacts a new Section 46 in relation to the acquisition of real property. Many of the provisions of the old Section 46 were obsolete and did not conform to other provisions of law on the subject.

Chapter 582 amends Sections 74 and 124 of the Mental Hygiene Law to correct in Subdivision 4 of those sections an error in the original drafting. Subdivision 4 of each section is designed to relate to procedures to be taken by the court in certification proceedings when no application is made for a hearing on behalf of the alleged mentally ill or mentally defective person. The language failed to state clearly the intent of the subdivision. Where, in Sections 74 and 124, reference is made to the observation of a patient, the words "and treatment" are added to correct an omission in the original drafting of these sections and provide authority in law for treatment of patients during the observation period. The law has not heretofore authorized this.

Chapter 213 amends Section 120 of the Mental Hygiene Law to require the department to discontinue the use of the facilities of Syracuse State School located within the City of Syracuse on or before July 1, 1958. The patients occupying such premises must be removed to other state schools within the department as soon as may be practicable.

Chapter 699 of the Laws of 1953, effective April 13, 1953, makes parallel changes in the law and procedures under Sections 85 and 134-a of the Mental Hygiene Law. The principal change in these procedures provides that the director of the institution, shall upon the order of the commissioner institute the proceedings for commitment and transfer of a dangerous patient to a correction institution. The district attorney, instead of instituting the proceedings as under the old law, now merely receives notice of the proceedings and may, if he wishes, participate therein. The proceedings remain the same in all other respects under the new law.

Chapter 482 amends Subdivisions 1 and 2 of Section 10-a of the Mental Hygiene Law to permit the transfer of a patient to a United States Public Health Service institution or facility. This law also amends Section 1384-o of the Civil Practice Act which relates to the commitment of incompetent veterans, by including a provision for commitment, under the procedures set forth, of seamen or other persons eligible for treatment to a United States Public Health Service hospital. This legislation was sponsored by the Federal Security Agency because of a desire to have authority in law for a transfer of patients pursuant to the Mental Hygiene Law to the United States Public Health Service hospital on Staten Island and also to provide procedures in the law for direct commitment of persons eligible for treatment to that hospital.

Related Statutes

Chapter 8 of the Laws of 1953 is part of the governor's program, as stated in his message to the legislature at the opening of the session. It extends the life of the Mental Health Commission to March 31, 1956. Similarly, as part of the governor's program, Chapter 9 was enacted to extend the life of the Youth Commission to July 1, 1956.

Chapters 612 and 613 were sponsored by groups in the City of Utica to authorize the sale by the state of certain lands at Utica State Hospital. Chapter 612 authorizes the sale of approximately 100 acres of the Utica State Hospital farm to the Utica College Foundation, Inc. It is proposed to place Utica College and campus on these lands. Chapter 613 authorizes the sale of about 28 acres of the Utica State Hospital farmlands to St. Luke's-Memorial Hos-

pital Center of Utica. That organization proposes to erect a 225-bed modern general hospital on the site at an estimated cost of $3,500,000.

Chapter 802 amends Section 6512 of the Education Law in relation to the practice of medicine in an incorporated hospital, state hospital, or state institution or in a hospital of a municipal corporation so that, under certain conditions, physicians holding a temporary certificate issued by the Education Department certifying their eligibility to take the state licensing examination may practise medicine.

Chapter 525, among other things, repeals Section 5511 of the Education Law in relation to extension teacher-training at Craig Colony by the State Teachers College at Geneseo.

Chapter 785 amends the Code of Criminal Procedure in relation to mental examinations of defendants in criminal actions and amends the Correction Law to permit the direct commitment of defectives over the age of 16 years to Napanoch and Albion institutions in the Department of Correction pursuant to Section 134-a of the Mental Hygiene Law and Section 662-b and 872 of the Code of Criminal Procedure. This major piece of departmental legislation is the result of several years study by a committee in the department and follows conferences with district attorneys and other public officials.

Section 660 of the code is amended to provide that the commissioner shall prescribe and furnish blanks for the commitment for mental examinations of defendants under criminal charge. The period of commitment for such examination is limited by this law to 60 days. The court is now required to commit such cases to an institution serving the institutional district in which the court is located. Section 662-b is amended to provide that if the court adopts the report of the qualified psychiatrists and commits a defendant for treatment, that commitment will be only to a correction institution.

The maximum fees of psychiatrists making these examinations are increased from $50 to $100 to keep step with changes in dollar value.

The amendments to Section 872 of the code (1) clearly place the duty on certain local officials to procure civil commitment of a de-

fendant found by a psychiatric commission to be in need of institutional care; (2) provide for such commitment to any appropriate institution in the Department of Mental Hygiene or Correction, and (3) eliminate the troublesome and anomalous status of such patients under the old law, where the criminal charge was deemed to "abate" upon civil certification. This is changed so that now the proceedings terminate when the finding of mental incapacity by the qualified psychiatrists is adopted by the court. Section 873 of the code is amended to place the duty clearly on certain local officials to procure the civil commitment of a defendant found by a psychiatric commission to be in need of institutional care. This is similar in this respect to the amendment to Section 872 of the code and was motivated by the same reasons.

Sections 438 and 451 of the Correction Law are amended to permit the direct commitment of mental defectives over the age of 16 years, pursuant to Section 134-a of the Mental Hygiene Law and Sections 662-b and 872 of the Code of Criminal Procedure, to the correction institutions at Napanoch and Albion without necessity for prior conviction. These amendments fit into the pattern of the Department of Mental Hygiene policy to provide for commitment of persons of dangerous and criminalistic tendencies to the correction institutions which are better equipped to care for them than the mental hygiene institutions.

Chapter 305 amends the administrative code of the City of New York to extend for another year the time in which the Department of Mental Hygiene is to remove patients from certain buildings of Manhattan State Hospital located on that part of Ward's Island set aside by the City of New York for park purposes.

A number of bills were introduced, that did not pass the legislature or were vetoed, which, if enacted into law, would have greatly affected the department and its institutions. One of these was a bill to provide legal assistance to mentally ill persons in connection with commitment proceedings and habeas corpus proceedings. It would have provided for the establishment of a unit in the office of the attorney general which would include a staff psychiatrist and a panel of psychiatrists to give independent psychiatric testimony on behalf of certain mentally ill persons. Another was a bill to amend Sections 658 and 870 of the Code of Criminal Pro-

cedure for examination of a defendant where there is reasonable ground to believe that he was mentally irresponsible at the time of the alleged act. A third was a bill to permit the commitment to civil state hospitals of convicts who have become mentally ill in penal institutions. A bill to add extensive provisions to the Code of Criminal Procedure relating to sanity examinations also failed of passage. This bill would have modified much of the existing procedure for such examinations and would have cut across the pattern of amendments to the code sponsored by this department.

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THE YEAR IN REVIEW

BY MARGARET M. FARRAR

When the fiscal year 1952-53 closed, there were 109,735 patients actually residing in the institutions and colonies of the New York State Department of Mental Hygiene and 12,865 convalescing in the community, a total of 123,324 on the books. This represented an increase of some 3,000 resident patients over the preceding year, a return to the trend of rising *increase* which had shown a temporary downward fluctuation in 1951-52.

Estimates of construction needs in the department are based on an average increase of 3,000 patients a year. The present construction program does not yet encompass these requirements, but it is helping to relieve current overcrowding. Of the 36 patient buildings provided for, nine have been completed including two large medical-surgical buildings on which construction was finished during the past year. One, at Hudson River State Hospital, contains 952 beds, and the other, at Buffalo State Hospital, 617. Seven more buildings, with a total capacity of 2,668 beds, are nearing completion.

The 1953 legislature appropriated to the Department of Mental Hygiene the sum of $163,000,000, of which $31,500,000 is for new construction. This brings to a total of $200,000,000 the amount set aside for the building program now in progress.

Treatment

A review of progress in the treatment of mental disease made at the end of the year revealed that patients entering New York State hospitals today have a better chance of recovery than ever before. Electric shock, the most widely used of the new therapies, is responsible for a great many improvements in discharge and recovery rates for functional disorders. The most dramatic improvement has been in the discharge rate for involutional melancholia, which rose from 28 per 100 admissions in 1935 to 81 per 100 in 1952. In the same period the recovery rate for manic-depressive psychosis rose from 66 to 83. There has been a tremendous rise, of course, over the past few decades in the chances for partial or total recovery from schizophrenia. The rate of partial or total recovery for first admissions with schizophrenia was slightly less

than 17 per cent in 1909. A recent study showed that by 1949 it had risen to 57 per cent.

New developments in the use of shock therapy have extended its applicability. Conditions such as advanced age or pulmonary tuberculosis are no longer considered an absolute bar to electric shock and in a limited number of cases the new relaxants have made electric shock application possible, even in the face of certain pathologies which would previously have ruled it out. In addition there has been an increasing use of electric shock for improving the condition of chronic patients suffering from severe behavior disorders. Such variations as the glissando technique, electric narcosis, regressive shock, and multiple treatments of less intensive nature are all in use or under trial, although standard techniques account for the bulk of the cases.

Dramatic results have also been achieved with psychosurgery. At present some 800 brain operations are performed in the state hospitals in the course of a single year. Most of these are prefrontal lobotomies but a few transorbital lobotomies and some topectomies are included. Surgical treatment is limited to patients who have not been responsive to less radical methods and has found a limited but important place in the treatment program. Reports indicate that improvement in the condition of patients suffering from chronic intractable behavior disorders has been hardly less important than remission produced in patients who are in comparatively early stages of their illness. The chronic group, only a few of whom recover sufficiently to leave the hospital, have been able to live much more comfortably and on a higher level in the institutions.

Penicillin has taken the place of malaria and other fever-producing therapies in the treatment of syphilitic meningo-encephalitis (general paresis), proving even more effective and much safer.

Concurrently with the extended use of somatic therapies, there has been considerable expansion in the use of psychotherapy. Group therapy, now increasingly applied in all of the institutions, is bringing psychotherapy to a larger number of patients and providing at the same time the peculiar benefits of group dynamics. Occupational therapy is also being literally brought to more patients each year through the services of the ward personnel, who function under the guidance of trained therapists. Recreational and

other rehabilitative therapies have been organized and expanded, largely through the creation of additional positions for trained personnel.

Family care and aftercare programs continue to grow. In 1935 there were 45 patients in family care. On March 31, 1953 there were 2,267. During the past year plans were completed for the reorganization of the aftercare service in the metropolitan area on a more efficient basis, eliminating duplication of services and making more effective use of social workers. The plans call for four aftercare clinics of an entirely new type in Brooklyn, the Bronx, Manhattan, and Queens. The clinics will have full responsibility for services to approximately 7,500 patients on convalescent care in New York City, mainly from the 11 state institutions serving the metropolitan area. The two existing aftercare clinics in Brooklyn and Manhattan will be converted and expanded as soon as the preliminary staff is organized and adequate space obtained. Under the reorganization the four clinics will be discrete, autonomous units and as patients are placed on convalescent status, they will be transferred from the care of a hospital to the care of a clinic.

Research

There has been in the department over the past few years a constantly widening emphasis on research. The entire program is now under the direction of Henry Brill, M. D., appointed assistant commissioner in June 1952. The year 1952-53 marked a departure into new fields as well as increased activities along established lines. In addition to general operating funds which normally provide for the regular research programs, the 1952 legislature appropriated a total of $343,200 for eight specific research projects. Four of these had been under way for some time, and the remaining four were initiated during the year.

Appropriations for existing projects included $57,300 for the psychosurgery study at the Psychiatric Institute, $100,000 for the Creedmoor Institute for Psychobiologic Research, $24,300 for investigations into certain aspects of mental deficiency at Letchworth Village, and $47,000 for the study of convicted sex offenders at Sing Sing Prison.

A new project of major interest, for which $25,000 was provided, was a survey of mental deficiency to include incidence; community

aspects of the problem; care and training for mentally retarded children, both in the community and in institutions; and an analysis of research needs. This study got under way early in the year with the appointment of an advisory committee headed by Deputy Commissioner Arthur W. Pense, M. D. Two phases of the study were partially completed during the year, a survey of the education of mentally retarded children being made for the department by Teachers College, Columbia University, and a study of the epidemiology of mental retardation in Syracuse and Onondaga County, conducted by the research staff of the Mental Health Commission with the co-operation of local agencies.

Other new projects for which special appropriations were made include an investigation of ketogenic diet treatment for epilepsy at Craig Colony, a study relating to the care of emotionally disturbed children, and a program of research in chronic alcoholism, the latter two to be conducted by the Mental Health Commission. All of these were started during the year.

In the fall of 1952 a comprehensive long-term project was established at Rockland State Hospital. Embracing co-ordinated studies in physiology, biochemistry, psychology, sociology, constitutional medicine, anthropology, and endocrinology, this project will attempt to demonstrate a common factor cutting across the lines of these various disciplines in their relation to mental illness.

The research unit of the State Mental Health Commission continued its series of studies on the patterns of occurrence of mental disease. The analysis of community characteristics of the pilot research area (the city of Syracuse and Onondaga County), based on census data of 1930, 1940 and 1950, is almost complete. These census data are being compared with data on the distribution of psychoses of the aged in the pilot area. Preliminary findings indicate a significant relationship between high hospitalization rates for mental illness of older people and living in multiple dwelling units. This relationship will be carefully analyzed in the next few months. Fourteen hundred persons aged 65 years and over were interviewed in selected neighborhoods in Syracuse as part of the study designed to estimate neighborhood differences in the prevalence of old age psychoses. Other research projects dealing with the distribution and origin of mental illness were continued.

Prevention

The program of prevention falls into two phases—provision of psychiatric services in the community designed to promote early diagnosis and treatment of emotional disturbances, and public education in the principles of mental hygiene.

The child guidance clinic program, considerably expanded during recent years with the establishment of new traveling clinic teams, has been able to meet only a portion of the total need, operating as it does in areas where no other facilities are available. Three new teams, however, were provided for in the 1953-54 budget. These will be set in operation as soon as the professional personnel can be recruited. Bringing the total to 14 fully staffed teams, the new groups will effect a substantial increase in the child guidance clinic service.

As part of its program of prevention, the Mental Health Commission spent a total of $110,000 for professional training and mental health education of related professional groups. This included 31 scholarship-stipends of $2,400 each or more for training in out-patient psychiatry, psychiatric social work, psychiatric nursing and occupational therapy. In addition 391 professional employees of the Department of Mental Hygiene took courses in their specialities on off-duty time as part of the commission's tuition payment program. A full child guidance clinic team, for the second successive year, received a year of training in an accredited child-training clinic.

Over 900 members of school personnel, including superintendents, principals, guidance workers and teachers, participated in the commission's mental health institutes on school mental health. Conferences and seminars were held for a large number of other professional workers, including public health personnel, clergy and correction workers. The commission's program to develop community mental health facilities included grants totaling $195,000 to 23 community child guidance and adult mental hygiene clinics and $100,000 to psychiatric services in two general hospitals. In addition, the commission inaugurated two new programs: three experimental resident treatment centers for children with personality disturbances—one each in Buffalo, Rhinebeck and New York City; and a program of financial aid to clinics for alcoholics.

There were several innovations in the public education program during the year. In April 1952 the department's Division of Public

Relations set in full operation its audiovisual aids library. This makes available on free loan to recognized local groups such educational aids as films, recordings, exhibits, posters, radio and television scripts. This material has been in constant demand throughout the year, as has the literature developed by the department for mental health education.

Two new productions were keyed to earlier publications still in very wide use. To the popular *Blondie* productions (including the comic book, animated exhibit, puppet show, and bookmark) was added a calendar featuring the ubiquitous Bumsteads demonstrating principles of good mental hygiene in everyday living. Introduced at the State Fair in September, this publication promises to be as successful as the now famous comic book. The new nonprofit Mental Health Materials Center in New York City, established in December 1952, has received permission to publish its own edition of the calendar for distribution outside New York State, relieving the department of the tremendous pressure of demand from all over the country.

The second new production correlated with an existing series was the *Guideposters,* a set of seven colorful cardboard posters designed to match the seven *Guideposts to Mental Health,* a series of popular style pamphlets now in their fifth printing. (About one and a half million of these pamphlets have been distributed since their introduction in 1949.) Single sets of the posters were offered free to recognized agencies and organizations in New York State in time for Mental Health Week in May 1952. Within three weeks some 800 requests had been received, and it became necessary to fill most of the subsequent requests on a loan basis.

Continuing to experiment with television, the division presented during Mental Health Week another dramatic show similar in format to *Fear Is a Phantom,* produced in the preceding year with considerable success. The 1952 program, *So High the Moon,* dealt with emotional problems of adolescents and featured Ted Mack as narrator.

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EDITORIAL COMMENT

IRREMEDIABLE ?

Death and damnation are irremediable conditions. So, in general, are the more serious congenital monstrosities and anomalies. Yet as psychiatrists, in whose specialty despair has given way to hope many times in our generation, we may be properly entitled to wonder if we are not inclined to classify too many "congenital" conditions among the more serious—with the dead and damned; the irremediable. There is active intervention as routine procedure today in some congenital conditions which once were considered hopeless: surgery, for example, in many cases of cardiac defect, and many orthopedic conditions. Surgery has been resorted to—as in a recently widely-publicized instance—to separate Siamese twins. Everybody knows, of course, of the nationwide attack on cerebral palsy by special physical training, surgery, medicine and psychotherapy.

We should like to raise the particular question here of whether psychiatry as a medical discipline and psychiatrists as a professional group have not been somewhat too prone to assign mental defectives of various grades to the serious and hopeless group of anomalies, whereas it now seems likely that something can be done to improve the lot of many of them. We have the impression, based on what seems to be constantly accumulating testimony, that many persons diagnosed as "congenital defectives" can be helped more than they ordinarily are, that still others can be helped more materially, and that some few can be brought to normal functioning altogether.

The problem of mental defect constitutes a subspecialty of psychiatry, not altogether unlike the problem of mental disorder in childhood, or perhaps the problem of delinquency. That is, it is a problem with which the majority of us come in contact only as an intercurrent condition in the course of major mental derangement, as we might come in contact with tuberculosis, cardiac disturbance or chronic alcoholism. We note the psychologist's report that this or that schizophrenic has an IQ of 68 and add "with mental deficiency" to his diagnosis, much as we might note on the physical examination form of this or that involutional melan-

choliac that he was suffering from hemorrhoids. The treatment of mental deficiency as a specific psychiatric problem is the task of a small minority, not the great majority of us.

We think that from the viewpoint of the great majority for whom contact is casual, some observations may be in order that the medical staff people of our schools for defectives should find elementary. Murray Bergman and Louise A. Fisher, writing in THE PSYCHIATRIC QUARTERLY SUPPLEMENT, Part 1, 1953, remark:

"The concept of mental deficiency is emerging from a morass of homogeneity. This is a happy development; but, unfortunately, this section of psychiatry seems to be only entering a stage similar to that which existed with regard to mental illness about three-quarters of a century ago, when psychiatrists were finally liberated from the idea that the mentally ill formed a rigid, undifferentiated, homogeneous and indistinctive heap of humanity to be removed from society, isolated and imprisoned. The great classifiers destroyed this medieval notion of uniformity and established the heterogeneity of the various forms of mental illness."

One can assume with safety that the authors had in mind not only Kraepelin but the later work of Bleuler with schizophrenia; and, while there are numerous pitfalls in the path of one who would track an analogy too far, it may be significant for the discussion of mental deficiency that Bleuler thought of schizophrenia as "the schizophrenias." Whether this is scientifically justifiable is a still earnestly and somewhat hotly debated question; but it has been a most useful concept in practice. More than one now outmoded idea has been useful practically: It was never the *mala aria* that brought the ague; but avoiding the districts of *mala aria* helped to avoid also the mosquito that did. And whether there is one schizophrenia, or a group of schizophrenias, or a syndrome that is characteristic of a number of unrelated disorders, the concept of plurality has been immensely valuable to psychiatry. It has, for instance, minimized the friction between organicist and functionalist to the point whereby both can pursue their own forms of treatment and research, with minimal throat-cutting and maximal observation of the laws of land warfare in the conflict which has naturally followed their diversity of viewpoint. This all seems to us to have had very practical results. The searcher for organic cause can hunt for his lesions and maintain with a clear conscience that this or that successful psychotherapist is not treating the

same form of disorder that the organicist calls schizophrenia; the psychotherapist can maintain with equally good conscience that the pathology claimed by this or that pathologist could not be found in genuinely schizophrenic patients. The neutral observer, if any, can agree that what they are both investigating is enough alike to deserve, for the time being, to be called by the same name.

Admitting that this is a compressed and thus unavoidably distorted version of current concepts and controversy, the psychiatrist concerned with mental disorder may find points to recommend it for consideration by the psychiatrist concerned with mental deficiency. With such at present comparatively negligible exceptions as hormone therapy—thyroid administration in cretinism for one instance—medical efforts in mental deficiency are at present chiefly ameliorative, curative neither in result nor purpose. Psychotherapy is—granting organic bases for all mental deficiency—generally dismissed from consideration as not even ameliorative.

As long as physical pathology is demonstrable, medical and surgical efforts to compensate or repair will continue; and we suspect that the tremendous efforts being made along this line, and the vast amount of clinical and research work being done on the physical aspects of mental defect are rather less than half-appreciated by those of us whose primary concern is not with defect but derangement. As long as psychiatrists are curious about the workings of the mind, some psychiatric investigation and some effort at psychological treatment of mental defect will continue also. But there has been a trend toward leaving psychological research to the psychologists and concentrating that largely on the business of intelligence testing, while psychiatric treatment has been hampered by the premise that there is little or nothing one can do for the defective anyway. Psychiatrists, who have observed the benefits—sometimes dramatic—of psychotherapy in mental disorder, must applaud at the least what seems to be a growing conviction on the part of those dealing with mental defect that psychotherapy, particularly along the lines of mental hygiene, has an important part to play in the alleviation of that condition also.

We would stress again the point that, like the physicians who deal with the schizophrenias, those who deal with the mental deficiencies also meet a multiplicity of conditions. The IQ is the accepted criterion for diagnosis, but the IQ is not the last word, and the IQ itself is not final. Some of our general conceptions are

basically at fault. Mongolism, for instance, is certainly not Mongolian idiocy, as it has long been called by non-specialists; Martin Lazar points to this in his paper on the subject in this issue of THE PSYCHIATRIC QUARTERLY SUPPLEMENT. Of Lazar's group of Mongols, nearly a third were of moron or borderline intelligence; about three-fifths were imbeciles; and less than one in 10 were idiots. The proportion of idiots in the Mongol admissions that Lazar studied was, in fact, only about a third that of the proportion in the total admissions of all classes of defectives to Newark (N. Y.) State School.

The concept of pseudo-feeblemindedness or pseudo-imbecility is, of course, well known; the relation of this to neurosis or to simple schizophrenia might perhaps best be discussed by specialists in the emotional difficulties of childhood. But the well-informed no longer put their trust in the IQ; whatever it measures, we no longer believe it is more than a general indication of certain—not all—inherited mental capacities; psychiatric testimony is all to the effect that it fluctuates widely under pressure of emotional circumstances; how widely it is affected by apparently non-traumatic differences in environment is a matter of a long-continued psychologists' dispute, but that it is so affected is now commonly accepted. "The defective individual," Bergman and Fisher note in their SUPPLEMENT paper, "is not simply an intelligence rating, but is a personality who has fears, anxieties, wishes and needs which affect his intelligence in varying degrees and courses." This is a needed statement—or re-statement—based on the authors' experience with administering the Thematic Apperception Test to defectives, of a principle to which we think most of us have long given verbal testimony.

But we think we have been more likely to express this principle than apply it, particularly those of us outside those schools where there is daily contact with defectives in numbers. The idea itself is no new one. About 50 years ago, Charles Bernstein became, as a young physician, head of what had been known as the New York Asylum for Unteachable Idiots and is now the Rome (N. Y.) State School. Bernstein did not believe his "idiots" were all unteachable or otherwise hopeless. He proceeded to teach them, to train them in useful occupations, to establish them in "colonies," to find jobs for them. Rome State School and other institutions based on his

enlightened concepts began to have graduates, and self-supporting, self-respecting graduates. The idea spread that one could teach defectives; and, today, defectives are taught.

The ideas that some defectives may not be essentially defective, that some of their retardation may be reversible, that many of them are suffering primarily from emotional disturbance rather than limited intelligence, have been slower to gain ground. In all of the 50 cases studied by Bergman and Fisher, there were disturbances classifiable under the categories used in the child guidance clinic. And these authors remark that "schizophrenic reactions in children are not infrequently mistaken for mental deficiency." The IQ alone is not enough, they note, for a differential diagnosis.

A low IQ, however, is ordinarily enough for certification to a school for mental defectives, in the absence of such full-blown psychotic symptoms as to bring hospitalization instead. For an extreme instance, we commend for attention the report of Luma Louis Kolburne in this issue of THE PSYCHIATRIC QUARTERLY SUPPLEMENT on the case of a boy with an IQ of 68 and a diagnosis of "mental retardation, congenital," who was admitted at the age of 13 to a private school for mental defectives. Mr. Kolburne, who was his counselor and teacher, reports that in five years the boy progressed from second grade elementary school work to be graduated with honors from the local public high school—a performance attributed to a method of largely supportive psychotherapy and carefully adapted educational procedures, in addition to cleverly contrived environmental manipulation. What his IQ was at the end of his high school course—he completed more than an average difficult one in three years instead of four and found time to be president of his freshman class and engage in extracurricular activities besides—is not stated. Neither does his teacher-counselor offer an opinion as to what his diagnosis should have been. Perhaps we should merely remark that the boy evidently belonged in the large group that Bergman and Fisher refer to as Leo Kanner's pseudo-feebleminded classification—and let the medical problem go at that.

These remarks are intended to present, for the benefit of the vast majority of us who do not deal primarily with the mental defective, an outline of some of the psychiatric problems involved. They are without prejudice to, and without reference to, any contention that the schools for defectives need more money for present work, should have enlarged or new research facilities, should be the focal

point of a new expansion program—or anything else of that sort. We have cited Bernstein's work as the pioneer effort to educate the defective and improve his lot through environmental manipulation (we might call it orthopsychiatry); we have noted Lazar to the effect that our common descriptive terms for defective classifications may be misleading and productive of unwarranted pessimism. Bergman and Fisher, we think, have demonstrated neatly —through work with the TAT—that the mental defective, as might be expected, is plagued with the problems which, with higher IQ's, would be considered ordinary neurotic or psychotic symptoms; and that, if these are not universal, they are extraordinarily widespread. The plain implication is that with improvement in these areas, improvement in personal happiness and in adjustment to the environment will follow—including, in many cases, improvement in IQ. And we cite Kolburne's report as dramatic illustration of this last.

We think we should conclude from all this—still for the benefit, of course, of those of us who do not have daily contact with mental deficiency—that there is a wider field and a greater reward for the application of dynamic psychiatry in the institutions for defectives than most of us have realized. We know that work not discussed here has been done on the problem, with the general conclusion to be drawn that adjustment can be greatly improved and that IQ's can be materially raised by psychotherapy in many instances, even when liberal allowance is made for overenthusiasm and for possible defect in scientific method.

We think Kanner's classification of pseudo-feeblemindedness is a useful concept, and propose to employ it. A pseudo-feebleminded person is one whose IQ is depressed by some factor other than inherent incapacity; it can be raised by treatment. But we ought to recognize at the same time that the term is semantic nonsense. It recalls the contention that schizophrenics who recover after psychotherapy cannot be "real" schizophrenics. But they are diagnosed schizophrenic by the same clinical standards as those who do not make recoveries; the pseudo-feebleminded are diagnosed feebleminded by the same standard, the IQ, as those whose conditions are irremediable. In both cases, there may either be something wrong with the diagnostic standard, or with our concepts of the conditions diagnosed; and in the case of mental deficiency, we suspect there are things wrong with both.

The diagnosis of mental deficiency is made with the aid of the psychologist and on the basis of the IQ. But the mental hospital psychologist is accustomed to make allowances for the depressing effect of emotional disturbance when he reports the IQ's of mentally ill patients. In view of the widespread incidence of emotional disturbance in the schools for defectives—not only as reported by Bergman and Fisher, but as noted by others also—we wonder if workers should not be encouraged to make similar estimates before diagnosing mental defect by IQ. We wonder, if through such a procedure, prognoses in many cases would not seem improved right at the diagnostic level.

We wonder if, with less hopeless prognoses, the psychiatric staffs of the schools for defectives could not be interested in increasing psychotherapeutic efforts, if group therapy in particular might not be worth trying on a comparatively large scale. If, by decrease of emotional tensions, more of the low-grade defectives could be brought to assume more of their own care, if more of the higher grades could be improved as institutional workers, if still more could be improved to colony or convalescent status, and if the unknown numbers of the pseudo-defective could attain IQ's within the normal range and cease to be responsibilities altogether, a full-scale, permanent program of psychotherapy in the schools for the mentally deficient would seem more than warranted.

We do not envision or recommend such an immediate development. As we have endeavored to emphasize, this discussion is intended to be entirely without prejudice to prevention, research and treatment endeavors now under way or contemplated. In a recent symposium, *Research into the Causes of Feeblemindedness,* published as a pamphlet at Letchworth Village (N. Y.) and included as Part II of the *Forty-third Annual Report of the Board of Visitors of Letchworth Village,* more than a score of medical experts on mental deficiency gave their views on directions into which research might profitably be pursued. Most of the work projected was, quite naturally, in the direction of physical pathology, into determining physical backgrounds for mental defect—in genetic factors, in birth and postnatal traumata, and in such matters as virus infection, anoxia and mineral lack in the mother during pregnancy. Without commitment to any specific or even general program, we are naturally in favor of all these efforts. We are nat-

urally in favor, too, of every effort that can be made toward prevention through education concerning the danger of birth accidents, virus infection, diet deficiencies, and unfavorable inheritance factors—where these last are surely known.

But as persons primarily concerned with the dynamics and function of the mind, we are particularly interested in the suggestions of several discussants in this research report that further study be made of emotional factors in mental defect. The effect on the defective of rejection and of social attitudes toward feeblemindedness was what most of these contributors had in mind; but we should like to quote from George S. Stevenson, medical director of the National Association for Mental Health, Inc., for he goes directly to our own point.

"There is . . . need," says Stevenson, "for taking more seriously the effect of dynamic psychological forces in the mentally deficient. We often act as if the intellectual impairment was sufficient to explain everything and that the same forces which affect the normals do not operate with the mentally deficient. I think we have blocked important progress by this attitude. The evidence of World War I showed that intellectual limitation, uncomplicated by neuroses or other emotional handicaps, could reach an unexpectedly low level without rendering the individual ineffective. By studying the emotional factors of mental deficiency I think we would not only contribute to the understanding and treatment of these cases but would reveal facts that would be of value to normal individuals." What we urge here is precisely this: greater psychiatric interest in "the understanding and treatment of these cases."

"See the happy moron
He doesn't give a damn."

We don't believe a word of it. We don't believe he is happy; and we are convinced that he does give a damn—perhaps in some cases so much of a damn that that is why he is a moron. We think we have noted here enough evidence to this effect to suggest that a vigorous psychotherapeutic effort in the field of mental defect might add considerably to the sum of human happiness. Or if this goal seems too optimistic, at least it might subtract materially from the sum of human misery.

BOOK REVIEWS

It's Not All in Your Mind. By H. J. Berglund, M. D., and H. L. Nichols, Jr. 332 pages. Cloth. North Castle Books. Greenwich, Conn. 1953. Price $3.95.

One-third of this book is devoted to a simplified description and outline of the psychiatric and the psychosomatic approaches to emotional illnesses, and to forms of treatment in use. The authors write well and clearly, but, if they intend to degrade psychosomatic medicine, they do a good job. The uninformed layman who reads this book and believes the authors' condemnations will think that psychiatrists and doctors of psychosomatic medicine are quacks and to be avoided.

In the authors' introductory page it is stated: "Their [psychiatrists' and analysts'] techniques are valuable in a limited field and contain promise of wider future application. However, their claims are far ahead of anything they have proved or accomplished, and they are causing serious harm to both the practice and spirit of physical medicine. The damage arises chiefly from a perversion of their doctrines to serve as an excuse to ignore ailments which make up a substantial fraction of national suffering."

After this frank introduction and after stating, "Our only defense against this kind of medical retrogression is to show both the doctor and the patient the evidence that diseases most often blamed on the mind are mostly physical, and that the best and shortest path to their cure is through the body rather than the mind," the authors switch to promulgating the idea that emotional illnesses are caused by physical defects which are expressed in allergic reactions. The layman must accept this as so, because Dr. Berglund is an allergist. To substantiate her ideas Dr. Berglund uses nearly all of the remaining two-thirds of the book to explain to the reader what the allergist knows and what he can cure.

In the concluding chapter further praise (?) of the psychiatrist and of the doctor of psychosomatic medicines is given ". . . The psychosomatic school is somewhat in the position of the baby who makes what he believes to be the original discovery that a dog has a tail. In his enthusiasm, he thinks it is practically the whole animal, and endeavors to use the tail to wag the dog. As his knowledge increases, however, his estimate of the tail shrinks down to its proper and secondary place in the pet's anatomy. . . . On the practical side, the physical approach offers more ability to help now, more definite knowledge of what it is doing. . . . On the psychotherapeutic side, we have a pitifully small group of qualified analysts and psychiatrists. . . . Our sick civilization needs them, and needs them badly, but they cannot take the place of our doctors. . . ."

Every psychiatrist will agree that *It's Not All in Your Mind* when one has emotional problems. But neither is it always an allergic reaction as the authors wish the reader to believe. In the understanding of mental problems no doctor should go to extremes. Emotional illnesses are not wholly physical or wholly mental. The mental symptoms are expressions of complex human beings.

Comparative Conditioned Neuroses. Edward J. Kempf, consulting editor. Annals of the New York Academy of Sciences, Vol. 56, Art. 2, p. 141-380. Illustrated. Paper. Published by The Academy. February 25, 1953. Price $3.50.

This monograph is a series of papers comprising a conference on Comparative Conditioned Neuroses in Human and Other Animals, held on February 22, 23, 1952, by the Section of Psychology of the New York Academy of Sciences. The papers present a considerable amount of data from the fields of experimental psychology and psychiatry regarding the problem of neurosis. Discussions of individual papers add stimulating material for the reader. This monograph is recommended for those interested in the experimental approach to the problem of neurosis emphasizing the comparative method and based mainly on learning theory.

The papers are of high caliber and are written by experts (Gantt, Liddle, James, Graham, Gellhorn, Fuller, Richter, Mahl, Masserman, Pechtel, Welch, Mowrer, Darrow, Kempf, Reese, Fleck). A fairly good balance is struck between research material and theoretical discussion. The monograph will probably not appeal greatly to the strict clinicians. It would seem, however, that the research frame is a healthy step in the right direction if the field of psychodynamics is ever to be called scientific.

The Loves of Florizel. By PHILIP LINDSEY. 208 pages. Cloth. Roy. New York. 1952. Price $3.50.

George IV enjoys the distinction of having been one of the most useless, as well as one of the most unpopular, monarchs the English ever had. Most of his waking hours were spent in a drunken stupor; the only thing serving to rouse him being his ceaseless pursuits of buxom women—who had to be considerably older than himself. This book concerns itself only with his private life, not entering into the history of the period except incidentally. The author traces the reasons for the King's neurotic personality, as well as his interest in older women, to a desire for maternal affection—that was conspicuously lacking in his own upbringing. The handling of the subject is too flippant and shallow to make this a good psychological study, but the writing style is good enough to make the following of the King from bed to bed interesting as light reading.

Writing Clinical Reports. By KENNETH R. HAMMOND and JEREMIAH M. ALLEN. 235 pages. Cloth. Prentice-Hall. New York. 1953. Price $4.00.

For some time psychological report writing in clinical work has involved largely trial and error learning, with a few basic rules and suggestions handed down from one's instructors. Now a book has been written attempting to formulate a comprehensive theory of the function and structure of reports, and the means of achieving the maximum efficiency in communication with conciseness and precision. As communication, whether written or oral, is primarily oriented toward influencing the behavior, i. e., opinions, etc., of the recipient, in this case the report reader, the authors carefully consider the problem and the means of conveying the report writer's thoughts about the subject to the readers, who may present a variegated background of experience, education and biases.

The authors assume the report writer has an adequate command of the language, and address their consideration to what may be called the "technique of reporting." In tone and in subject, this is a basic guide, primarily directed to graduate students. The elementary tone of the book is suggested by the chapter titles, i. e., "Organization," "Style, Accuracy and Integration," "Vocabulary," etc., but it is not to be slighted by the more experienced clinician. In general, it is a long-awaited book, which fulfills a long-unsatisfied need; it is strongly recommended, especially at the graduate student level. A varied and illuminating assortment of typical reports is provided, and each step in exposition is carefully and judiciously demonstrated.

Encyclopedia of Aberrations. Edward Podolsky, M. D., editor. viii and 550 pages. Cloth. Philosophical Library. New York. 1953. Price $10.00.

The reader, when purchasing an encyclopedia of this kind, has the right to expect work of uniformly high quality. While it cannot be denied that many of the articles in this book are of great value in their own right, others, where a high standard is not maintained, serve to lessen the value of the book as a whole. The editor seemed unable to make up his mind whether his purpose was to compile a reference book or a bit of sensationalism, and the result has been to make this encyclopedia unsatisfactory in either respect.

In such articles as the one on "Devil Worship," where sensationalism could most easily be brought out, real psychiatric implications have been ignored. The "Devil Worship" article, in addition, contains much material which is not generally accepted, and it is unsigned—an unobjectionable practice where matter is not of doubtful validity, but an objectionable one

where authority should be given for unconventional opinion. In contrast to the popular, undocumented and sensational, some of the other articles in the encyclopedia are so technical as to make them virtually incomprehensible to the general reader; and references, even in cases where they should be recognized as a necessity, are missing.

Finally, the publishers have used intentionally such a wide definition of "aberration" as to cover most of the psychiatric field. The introduction includes an able defense of this usage; but the title remains misleading, for professional purchasers will discover that, instead of having bought a reference work on sex abnormalities, they have an indifferent collection of more general psychiatric articles and definitions. The purchaser of erotica—who will be lured by an inappropriate dust cover with fetishistic decorations—will be equally disappointed.

The Great Enterprise. Relating Ourselves to Our World. By H. A. OVERSTREET. 332 pages. Cloth. Norton. New York. 1952. Price $3.50.

The author of *The Great Enterprise* is Harry A. Overstreet, who also wrote *The Mature Mind*. This new publication deals in passing with many facets of our psychological selves—the context of our self, the egocentricity of people, the tensions of our day, our spiritual frontier (whatever that means), and other more or less broad aspects of man in relation to Man. Mr. Overstreet rehashes the forgivable principle that "psychological maturing is something over and above physical maturing." In his own words again, the author writes: "I undertook (in *The Mature Mind*) to speak for the importance of this 'maturity concept' to individual development and to certain institutions of our society. In the present book, I am venturing to explore more fully its importance to our social development."

With similar rampant generalizations throughout *The Great Enterprise*, Mr. Overstreet writes of the relationships of ourselves to our world; and produces then not an erudite book, to be sure, but a satisfying and suggestive, even an informative diatribe on many matters of a quasi-philosophical and pseudo-psychological nature. The book is highly readable; the author's sedulous effort at the quick phrase, the arresting sentence, and the compact idea are all to his credit. At times it reads like a connected series of magazine pieces, but with sufficient cliché phraseology so that technically and semantically, it often leaves the reader quite unknowing just what Mr. Overstreet really meant to say. The author has the ability of fluent and facile writing, but after one finishes the book in its entirety, one is prone to ask, "Just what was *really* said in *The Great Enterprise* that makes it especially worthy of publication in book-format? What *is* the basic message that has not been said better, more concisely, and memorably elsewhere before?

Rorschach Interpretation: Advanced Technique. By LESLIE PHILLIPS and JOSEPH G. SMITH. 385 pages. Cloth. Grune & Stratton. New York. 1953. Price $8.75.

As the authors state in the foreword, "This book is intended primarily as a practical clinical reference." As such, it should prove very useful as a clinical manual for practising clinical psychologists as well as a supplementary test for instructors of advanced courses on the Rorschach. It will do little to advance the Rorschach as a scientific instrument, however, since it is based mainly on empirical clinical practice and does not purport to be a validation study. Thus, the scientific worker will find little here beyond speculation and empirical deductions based on clinical practice. At times, this speculation becomes difficult to take, particularly in the chapter on "Attitudes, Role Playing and Life Thema," where the authors attempt to infer a testee's role concepts mainly from the side remarks and comments which he makes. This reaches rather ludicrous proportions in such highly speculative inferences as the following:

"'O. K.' implies that the subject has mastered the situation and is able to participate actively in it, but only within the limits established by the examiner. 'Now' and 'o. k.' when they initiate a response, represent a methodical ordering of his response pattern by the subject and so imply obsessive features. Both emphasize the tasklike character of the situation for the subject. 'Now,' alone of these delaying remarks, implies intellectual vigor and mastery." It seems to this reviewer that the authors could well have omitted such dubious speculation, since actually the important thing, as far as the psychologist is concerned, is the interpretation of the test protocol itself, i. e., *what* the subject sees.

The chief assets of the book for this reviewer are the chapter on content analysis which fills a real need since little has been published in this area; the generally good documentation throughout so that the book serves a real purpose as a reference source with concrete data for the practising clinician; the generally clear exposition throughout; and the liberal references to the works of leading authorities on the Rorschach. Although there are detailed sections on interpretation including sequence analysis, some of this material seems unwieldy in being too detailed, and in trying to tease too much out of dubious side remarks, etc.

The first several chapters of the book discuss the various test factors such as form level, location, color, movement and shading. The middle chapters take up content analysis, role playing, and the concept of shock. Chapters on interpretation with detailed case presentations conclude the book. Tables for F+ and F— are included in the appendix. This book can be recommended as a useful, up-to-date clinical source reference on the Rorschach Test. As indicated in the title, it is not for beginners, but should prove useful to advanced students and to workers in the field.

A Manual of First Aid for Mental Health. In Childhood and Adolescence. By SIDNEY L. GREEN, M. D., and ALAN B. ROTHENBERG, M. A. 278 pages. Cloth. Julian Press. New York. 1953. Price $4.00.

"Do you know of a book I can purchase that will help me to understand my youngsters' nervous or behavior problems better?" This is a question frequently directed to persons who treat such problems or who lecture on mental hygiene subjects.

Referring particularly to parents, the authors state: "For this vast army of 'drafted' First Aiders for mental health, there has, up to the present, existed no organized guide. To our knowledge, no clear-cut distinction has ever before been offered them as to what constitutes First Aid for mental health and what constitutes professional psychotherapy (treatment) for mental illness. As an interested reader, you could not, for example, find any book on mental health First Aid corresponding to the American Red Cross' First Aid Text-book.

"The situation is particularly unfortunate where the welfare of children is concerned. For, with no trustworthy distinctions at hand as to what constitutes First Aid for mental health, should you want to help an emotionally upset child, you would have no way of telling whether what you were attempting was merely permissible First Aid practice, or whether you were overstepping your bounds into the area of psychotherapy for mental illness, where the professionally trained alone should take charge."

In their challenge to this great need, the authors first describe what is meant by emotional and mental health; how serious is the problem of mental illness, and their methods of applying first aid. They then describe 25 different emotional problems expressed by children and adolescents. Finally, they tell the reader how to obtain professional assistance. The book contains two appendices: One describes the various ways in which a youngster reacts to stress situations and the second is a glossary of terms or technical words used in the book. There is also a good bibliography.

Two hundred thirty-eight of the 276 pages of this book are devoted to unique methods of first aid for emotional problems. These discussions are extremely good. Here is an example to permit better visualization of just how the authors set up each program for first aid. "SITUATIONS: First Aid for the Child Disturbed by Desertion of One or Both Parents" will be analyzed. First, the authors tell the reader just how the child looks at the situation or "Behavior Patterns and the Meaning of the Situation for the Child." Then follow, "Persons Best Suited to Render First-Aid," "Goals of First Aid," "First Aid Methods: DON'T's," "First Aid Methods: DO's," "When to Obtain Professional Assistance," "Prognosis," "Workshop Example No. 1" (brief case history), "Discussion Questions," "Workshop Example No. 2" and "Discussion Questions."

Out of the many books written relating to the emotional illnesses and to mental hygiene there comes, now and then, a book which is extremely good and which deserves attention. ***A Manual of First Aid for Mental Health*** is such a book. It will become a very important book, not because it presents new ideas but because it presents a clear, systematic method whereby parents, parent-teacher organizations, social workers, ministers, teachers, counselors and many others can approach and better understand the emotional problems facing youngsters. Each problem is so well explained, simplified and organized that one can imagine a parent-teacher organization allowing time each meeting night to have some person read one section of this book, and then allowing time for general discussion.

Collegiate Education for Nursing. By MARGARET BRIDGMAN. 205 pages. Cloth. Russell Sage. New York. 1953. Price $2.50.

In common with many other authorities in the field, the author stresses the importance of collegiate education for the members of the nursing profession. It is held that the administration of the collegiate schools of nursing should be divorced from the hospitals, and that entrance into one of them should be in no way different from entrance into a university devoted to the liberal arts.

This is a highly commendable ideal, but there is much room for doubt of the practicability of the plan. The problem of financing is passed off by holding that the student, as in other forms of higher education, should pay the costs of the education—with, of course, a fairly extensive system of scholarships in force. The number of nurses that belong in the collegiate programs is considered to be about one-half of the total.

While it is true that a general raising of standards in nursing would attract people to the field who currently devote themselves to the liberal arts, this reviewer considers that this gain would be more than offset by the numbers of potentially good nurses unable to enter the field for financial reasons. Scholarships are wonderful things, but even our best endowed universities are limited as to the number they can give out, and this would be doubly true when starting out a new program.

Catch-As-Catch-Can. By CHARLOTTE ARMSTRONG. 219 pages. Cloth. Coward McCann, Inc. New York. 1953. Price $2.75.

Here is another novel of suspense, by the author of ***The Unsuspected***, and ***Mischief***. In these previous works, the writer proved herself a master of the art of suspense. Again we have a story filled with excitement and tension. With a plot perhaps not quite so plausible as the others, this will still be a must for all Charlotte Armstrong fans, and a most readable tale for anyone. The psychology, as in all this author's works, is adequate. Maybe the plausibility of the plot itself should be a question for the internists.

Fundamental Concepts in Clinical Psychology. By G. Wilson Shaffer and Richard S. Lazarus. XI and 540 pages. Cloth. McGraw-Hill. New York. 1952. Price $6.00.

The authors have undertaken to tie together the complex and often ill-defined field of clinical psychology. They claim to offer a rather systematic book which emphasizes theoretical, methodological and practical foundations of the subject matter.

The book affords the beginning student of psychology a broad view of the field in that information is assembled in one text; but whether such a student can critically evaluate the basic concepts, as the authors purport to do, is questionable. Great stress is put on methodology. "Many clinicians, apparently lacking in scientific understanding, have claimed scientific status to what is little better than a hodge-podge of pretentious word salads . . . they have retreated behind the belief that the practice and theory of clinical psychology must be a subjective art and therefore does not demand the distasteful rigors of scientific methodology." With this suggestion that poetry be translated into prose, the authors fail to inform us just what are "the excellent opportunities to explore new and old techniques which are methodologically sound and which still hold realistically to the kinds of special material which the clinician deals with."

Other chapters of the book are rather disappointing. They are, for the most part, a recapitulation of material from basic sources. The authors have also failed to include recent research findings.

The chefs are new, the ingredients the same, and we have all seen the recipe before.

Personality and Adjustment. By William L. Patty, Ph.D., and Louise Snyder Johnson, Ph. D. 390 pages. Cloth. McGraw-Hill. New York. 1953. Price $4.75.

The interpretation of emotional problems continues to be difficult to explain and to teach. In the varied fields of psychology and psychiatry, no two educators express their ideas in the same way. Each educator has a unique method of understanding and interpretation of personality maladjustments. Such is the case in *Personality and Adjustment*. The authors write simply yet specifically about personality development and problems of adjustment. They call attention to the need for increased mental health; the facilities now being used; the basic dynamics in personality growth; the influences of marriage, the home and family; the various methods or symptoms used by a person in his expression of mental ill-health and various methods of adjustment which may be used.

In their preface, the authors state that the style of their book is a result of their experiments in teaching, and they recommend it as an introductory course in the psychology of personality. After each chapter, they list questions for discussion and suggestions for additional reading.

The Murder of Sir Thomas Overbury. By WILLIAM MCELWEE. 280 pages. Cloth. Oxford. New York. 1952. Price $4.50.

With the coming to the English throne of James I, sound administrative policies set up by Elizabeth were relaxed. Whichever young courtier held position as the King's favorite largely controlled the destinies of everyone in the Court. Robert Carr, however, lacked the ability to exercise these powers himself, and Sir Thomas Overbury became the man behind the favorite. The result of this particular situation was that Carr's prospective bride found it necessary to rid herself of Overbury. A variety of expedients were tried, including black magic, with several large doses of poison finally proving successful. Discovery of the murder and the subsequent trial upset the entire Court structure and formed the background for the rise to favor of Buckingham as new favorite. The author has stated as fact conclusions which are not completely accepted by all authorities, but has proved successful in making comprehensible and interesting this muddled period in English history.

S. Weir Mitchell as a Psychiatric Novelist. By DAVID M. REIN. xv and 207 pages. Cloth. International Universities Press. New York. 1952. Price $3.50.

The work of S. Weir Mitchell in the field of psychiatry was limited by the framework of the period in which he lived, but within this framework he did a great deal. It is not surprising that his novels should contain many characters of psychiatric interest—but here again the studies deal with effects and not causes. This book traces the influence of psychiatric practice on the novels as a whole and on individual characters. The level of reader interest is not high enough to make the book enjoyable to others than students of the period.

The Family Problems Handbook. How and Where to Find Help and Guidance. By ARNOLD W. HOLMES. 191 pages. Paper. Frederick Fell. New York. 1952. Price $2.00.

The Family Problems Handbook is a comprehensive guide to over 500 social agencies organized to help the millions of people who are beset by problems too difficult for the individual to solve. Almost every conceivable type of problem is discussed. Specific agencies, selected readings and references are offered.

Not only is this a handy tool for the professional person, but it should be suggested to the layman as a valuable reference work.

Don't Be Afraid of Your Child. A Guide for Perplexed Parents. By HILDE BRUCH, M. D. 297 pages. Cloth. Farrar, Straus & Young. New York. 1952. Price $3.75.

Dr. Hilde Bruch's guide for perplexed parents, entitled *Don't Be Afraid of Your Child*, is a quiet book, mostly correct, but somewhat biased against "child psychology," and psychologists, too. Somehow, the author erroneously suggests that parents are "charged" by their children, and must defend themselves, after a fashion. "Modern parents," writes Dr. Bruch, "are beset with the most amazing number of questions and worries." It is this reviewer's opinion that today's parents have actually no more worries or questions than the parents of yesteryear; only the very nature of our contemporary parents seems to have changed.

In this book are many trite but basic statements of credo. The author states platitudinously, "Parents must learn to use methods that are appropriate for themselves, their children and their circumstances." And elsewhere, not so intelligently or well-informed, "A basic error of current psychological teaching is that it often overlooks the root problems of the modern family." But Dr. Bruch does save the worthiness of her book in her underlying thesis that parents must accept themselves as decent human beings, who are what they are, and must respect each other in their appointed tasks, obligations, responsibilities and prerogatives.

Perhaps a major limitation of this volume is its lack of a positivism of approach; it is more "agin" than "for," especially if the proposition happens to be contemporary or psychological. It is, nevertheless, a reassuring book, a book with many fine attributes of insight in pediatric thinking. Perhaps Dr. Bruch has missed the forest for the trees in her final analysis of child psychiatry and pediatric care, but she is forthright and fair in intention, determined and argumentative; and the book is interesting and meaningful.

Groups in Harmony and Tension. By MUZAFER SHERIF, Ph.D., and CAROLYN W. SHERIF, M. A. 307 pages. Cloth. Harper. New York. 1953. Price $3.50.

As time moves on, one realizes how small the world really is. One realizes that no longer are races or groups of people able to live in their snug little individual worlds. Ordinary intragroup relationships are still very important, but intergroup friendliness is more and more necessary.

The authors review traditional racial and nationalistic methods of living together (intragroup) and review current information about prejudice and cultural obstruction. They formulate an objective approach toward improving intergroup relationships. Their theoretical recommendations are substantiated with illustrations from sociological studies, and their theories are tested by an experiment carried out as part of the "Attitude Change Project" at Yale under the direction of Prof. Carl. I. Havland.

Men, Atoms and God. By PAUL SABINE. 219 pages. Cloth. Philosophical Library. New York. 1953. Price $3.75.

This book reveals a great deal about the author. He is a specialist in the field of physics, but he is also familiar with the fields of psychology, history, philosophy, and religion. In this attempt to make a synthesis of the findings of modern science and psychology and of the basic teachings of the Christian faith there is revealed a deep insistence upon truth. Half truth is rejected many times. At the same time, Sabine honestly admits that he is not always entirely objective.

The heart of this book is not the collection of scientifically demonstrable facts, even though these facts will make a lasting impression on the reader with some scientific training; but it is the faith of the author that God and atoms and the human soul are one in essence. This faith, however, takes into account all the facts that have bearing on the subject.

Sabine shows that modern science and religion come together on common ground when science says that the final structure of the world has a mental quality. Actually many readers will be happy to find that science and religion have never been as far apart as they were led to believe. From their common origin in man's urge to control his environment, religion and science are traced briefly through the ancient philosophers and scientists and on through the mechanistic world view of the seventeenth century. The layman without specialized training will be thrilled by the way Sabine traces the evolution of scientific thought from mechanistic determinism to the discoveries that, the man of religion may believe, cause the world to appear more like the expression of a universal mind.

This book is very realistic and yet optimistic and even inspiring. In a convincing and reasonable way, Sabine argues that the world and its people are not part of a machine that is running down. Rather, the world and its people have a vital, growing, evolutionary element that is seen in modern science and psychology and also in history and religion.

The Dynamics of the Counseling Process. By EVERETT L. SHOSTROM, Ph.D., and LAWRENCE M. BRAMMER, Ph.D. XVI and 213 pages. Cloth. McGraw-Hill. New York. 1952. Price $3.50.

The major emphasis of this book is a description of a counseling procedure beneficial in adolescent problems. The authors have written for high school and college counselors. Their orientation is non-directive; but the Rogerian type of counseling has been modified for effectiveness with high school and college age groups. The authors recommend giving specific vocational and occupational information, as well as the use of psychological tests.

Detailed counseling interviews are presented with a discussion of the specific processes involved.

Applied Psychology. Abridged Edition. By HAROLD ERNEST BURTT, Ph.D. 453 pages. Cloth. Prentice-Hall. New York. 1952. Price $4.75.

This abridgment, in the author's own words, was written "partly in response to the suggestions from some teachers that the original edition contained too much material for the time available, and partly for the benefit of those lay readers who found the other edition too exhaustive in content." In this edition some of the examples and illustrative material have been reduced while topics which the author feels are of lesser import have been omitted. The result is a more readable and more compact presentation than the original edition, yet the field of applied psychology is adequately covered in its broadest scope. Individual differences, vocational guidance, clinical psychology, criminology, industrial psychology, advertising and selling and elementary psychological statistics are all given somewhat detailed coverage, while many other topics such as learning, heredity and eugenics are discussed in lesser detail.

The reviewer is familiar with Dr. Burtt's original edition of *Applied Psychology* and found that work to be a practical and valuable source book.

In this abridgment, the coverage remains so broad and detailed that the omitted material has done little more than deprive the text of some of its reference value. Though of lesser worth to the esoteric than the original work, the present abridgment is of more benefit to the lay person. The reviewer is of the opinion that the author has succeeded in giving a good overall view of the broad field of psychotechnology which is presented so that it is within the limits of understanding of the reader who is unfamiliar with the material; yet the contents are of sufficient depth and detail to merit the attention of the more experienced.

Forty Odd. By MARY BARD. 253 pages. Cloth. Lippincott. Philadelphia. 1952. Price $3.50.

Forty Odd is a newsy, interesting and rather breezy book by the wife of a physician; Mary Bard is an intelligent lady who is to be commended for a satisfying insight into the matter of years added to years—especially after one has reached 40. The author rightly thinks of age as a number and not as a disease. The contents page is uniformly alphabetized with the letter "F": Chapters are headed "Frail, Fat or Fortitude," "Flora, Fauna and Futile," "Family, Facts, Food or Fad," and other such arresting titles. The book is highly dialoguish, with determined—and almost unrelenting—efforts at hilarity and facetiousness. *Forty Odd* is a lighthearted volume, with many suggestions on how to act, live out, and benefit from, the years after 40. Gerontologists and geriatricians might wish to recommend this book to clients and patients for some of the ideas dealt with by Mary Bard.

A Practical Guide for Troubled People. By LEE R. STEINER. 299 pages. Cloth. Greenberg. New York. 1952. Price $3.50.

"The average person seeking help with a personal problem is often belligerent because it seems to him that professional consultants make everything seem so complicated. . . . Following the publication of 'Where Do People Take Their Troubles?' I received thousands of such complaints in letters from people who had already sampled the assistance of professional consultants and found it wanting. . . . They complained that they found what not to do, but were left stalemated as to constructive resources. . . . It is in answer to that need that I have written this 'guide-book'."

One wonders if the author has accomplished her purpose. One wonders if her severe criticisms of the psychiatrist, the psychoanalyst, the psychologist, the social worker and even the minister will not confuse rather than guide. One admits that there are "quacks" in all of these professions, but a very large majority are sincere, ethical counselors. One wonders if the author, in her effort to warn the "troubled" person against employing the unethical counselor, has not, unintentionally, shaken confidence in the ethical one. Warning about the unethical is not guiding to the ethical.

In a final brief chapter the author writes, "You now recognize that psychological counseling is not the open Sesame to all good things in life. It can, however, be of help in solving many personal problems, if used wisely. If not used wisely, it may prove to be not only a waste of money but a great frustration. . . . For larger issues, for a sense of direction, you still must develop your own resources. . . . Instead of using your spare time to escape, use it to understand—to understand the nature of the world in which you live and specifically of yourself. You must still attain emotional poise the hard way—by finding the formula yourself."

Health, Happiness and Hormones. The Gland and Sex Dilemma. By MAX R. RUBENSTEIN, M. D. 223 pages. Cloth. Hermitage House. New York. 1952. Price $3.00.

This book is written for the layman. It is a discussion of the endocrine glands and how they affect health and personality. Dr. Rubenstein tells how hormone therapy helps in the treatment of a great many physical and psychological disturbances.

Hostages of Civilization. By EVA G. REICHMANN. 281 pages. Cloth. Beacon Press. Boston. 1951. Price $3.00.

The author traces the tide of anti-Semitism in Germany during the Hitler regime and considers the difficulties of assimilation into a position of equality to be a major factor. This is an undistinguished book, not having the depth of outlook necessary in a study of complex social causations.

Medicine for a Sick World. By DAVID LEFKOWITZ. 238 pages. Cloth. Southern Methodist University. Dallas. 1952. Price $3.75.

The title of this book is as appropriate as it is fascinating. It is a summary of the literary achievements of a lifetime by a man who has given his life in diligent studies in both libraries and laboratories discovering the best medicine for a sick world and the best methods and programs for its application to the world.

The book is divided into two parts. The first is composed of five essays which attempt to reappraise one of our fundamental institutions of American freedom, the leading institution of the Jewish community, the synagogue, along with the supreme messages of such mis-evaluated thinkers as Spinoza and Goethe.

Part two deals with a number of sermons which give us the best in modern Jewish thought and life. The author gives evidence in these sermons that his feet are on solid ground and that he has walked along the way of life with his fellowmen of all faiths. Whether the reader be Protestant or Catholic, if he believes that a better day can be had, "an age of true democracy and true religion founded on freedom and human equality, on justice and brotherhood," he has found a kindred spirit in this Jewish author.

Introduction to the Rorschach Technique—Manual of Administration and Scoring. By ROBERT M. ALLEN. 126 pages. Paper. International Universities Press. New York. 1953. Price $3.00.

This book is a three-part manual on the administration of the Rorschach test and a short text on scoring. Part I discusses briefly the theory of the test and takes up the mechanics of test administration, such as physical arrangement, giving of directions and the recording of responses. Part II discusses the location, determinant, and content categories, giving examples of the various scoring symbols. Part III takes up the inquiry into the percepts, including the testing of the limits.

The last part of the book is concerned with the tabulation and making up of the psychogram. The author states the book is designed for a one-semester course in Rorschach administration, inquiry and scoring. In general, it is well written, but it would seem that in places the material is rather advanced for the beginning student. The book should also be of value as a laboratory source and reference work in scoring of this test. It can be criticized on the grounds that it is too concise in discussing some of the important determinant areas, and also in that it does not give sufficient examples of borderline type responses—something which would be of value to the student in scoring.

CONTRIBUTORS TO THIS ISSUE

LUMA LOUIS KOLBURNE, M. A. Mr. Kolburne was born in New York City on December 17, 1898. He received his A. B. degree from the College of the City of New York where he majored in education and psychology. He received his M. A. in psychology from Columbia University in 1921. From 1921 to 1945 he was the senior master and guidance director at Bailey Hall, Katonah, N. Y., where the boy whose case is reported in this issue of THE SUPPLEMENT was studied.

In 1947 he established the Kolburne School for children with emotional, behavior or learning problems. It is located in Norwalk, Conn., and is accredited by the Connecticut State Board of Education. Mr. Kolburne is particularly interested in research in the education of mentally retarded children. He is a member of the American Psychological Association and the American Association on Mental Deficiency and other professional organizations.

JAMES H. WALL, M. D. Dr. Wall was born in Lancaster, S. C., was educated in Chester, S. C., at the University of North Carolina, and at Jefferson Medical College of Philadelphia. He has been on the medical staff since 1928, and has been medical director since 1946 of the New York Hospital—Westchester Division, White Plains, N. Y. He is associate professor of clinical psychiatry at Cornell University Medical College.

MARTIN LAZAR, M. B., Ch.B. Born in New York City in 1909, Dr. Lazar is a graduate of the College of the City of New York. He obtained his medical degree from the University of Glasgow, Scotland, in 1934. He was house surgeon at the Durham County Hospital and house physician at the Sunderland Royal Infirmary. He returned to the United States in 1937, and joined the staff of St. Lawrence (N. Y.) State Hospital. He transferred to Hudson River State Hospital in 1947. Since September 1, 1950, he has been assistant director (clinical) at Willowbrook State School. He was appointed assistant clinical professor of pediatrics at New York University-Bellevue Medical College on January 1, 1953. He is a diplomate in psychiatry and a member of the American Psychiatric Association.

J. MARSHALL BRUCE, JR. Mr. Bruce was graduated from Princeton University in 1943 with a major in psychology, did graduate work in clinical psychology at the University of Michigan, and for two years held a research fellowship in the same field at the Johns Hopkins University School

of Medicine where he participated in the project upon which the study in the present SUPPLEMENT is based. Mr. Bruce also spent several years practising clinical psychology in the Maryland state hospital system.

CAROLINE BEDELL THOMAS, M. D. Dr. Thomas is an associate professor in the department of medicine at the Johns Hopkins School of Medicine, Baltimore, Md. Since 1946 she has been the director of a research project concerned with the precursors of hypertension and coronary artery disease, using Johns Hopkins medical students as subjects. The paper in this issue of THE SUPPLEMENT is one of a series which has appeared regarding the occurrence of various hereditary physiological, metabolic and psychological factors which may be of importance in the etiology of hypertension or coronary artery disease. The research project, originally carried out under the department of preventive medicine, has recently been transferred to the department of medicine, since the former department has gone out of existence.

IZETTE DE FOREST. Mrs. de Forest is a graduate of Bryn Mawr, class of 1910. A field worker for the Connecticut Society for Mental Hygiene from 1923 to 1925, she had a therapeutic and training analysis from Sandor Ferenczi from 1925 to 1927 and again in 1929. She has been in the non-medical practice of psychoanalysis since 1927. She had additional training under Erich Fromm from 1942 to 1945. Mrs. de Forest has practised in New York City and Cambridge, Mass., and is now practising in Boston and in Marlborough, N. H.

H. E. LEHMANN, M. D. Dr. Lehmann received his M. D. in Berlin in 1935 and was a resident in neuropsychiatry at the Jewish Hospital, Berlin, in 1936. He has been with the Verdun Protestant Hospital, Montreal, since 1937, serving as junior and senior psychiatrist, and, since 1947, as clinical director. He was lecturer in psychiatry at McGill University from 1948 to 1951, and has been assistant professor in psychiatry at McGill since 1951.

JOSEPH MECHLOW, M. D. Dr. Mechlow was born in Vienna in 1915 and received his general, and part of his medical, education there. He completed the latter in Switzerland, where he was graduated with his medical degree from the University of Zurich in 1946. He interned at St. Vincent's Hospital, Staten Island, N. Y., shortly after coming to the United States in 1948. From 1949 to 1950, he was assistant psychiatrist at Weston State Hospital, Weston, W. Va. He entered New York State service as

resident psychiatrist at Hudson River State Hospital in 1950 and was later appointed senior psychiatrist there. He is at present on the staff of Rockland (N. Y.) State Hospital.

MARVIN L. ADLAND, M. D. Dr. Adland is a graduate of the University of Chicago School of Medicine, 1943. He served a general rotating internship at the Milwaukee County General Hospital, Milwaukee, and a residency in psychiatry at the Sheppard and Enoch Pratt Hospital, Towson, Md., before entering the army in 1944. In the army, he reached the rank of captain and the position of chief of neuropsychiatric service, station hospital. He became a resident in psychiatry at Chestnut Lodge, Rockville, Md., in 1948, then served as staff associate there, and has been clinical administrator of that hospital since 1951. He is a diplomate in psychiatry of the American Board of Psychiatry and Neurology, is a member of the American Psychiatric Association and other professional societies and has contributed previously to THE PSYCHIATRIC QUARTERLY.

SELINA SCHRYVER, M. D. Dr. Schryver is assistant in psychiatry at Columbia University, is on the staff of the Vanderbilt Clinic and is former director of the Child Guidance Clinic at the New York Infirmary.

She is a graduate of the University of Amsterdam, Holland, and has studied at the Salpêtrière in Paris. She has published a series of articles on clinical psychiatry and physio-chemical research in psychoses.

E. DAVID WILEY, LL.B. Mr. Wiley is associate attorney in charge of the legal division of the New York State Department of Mental Hygiene. He has been in state service for 16 years and with the legal division of the Mental Hygiene Department for the past two. Born in Maine in 1908, he attended elementary and high school in Maine and New York State, attended the University of Nebraska and received his law degree from Albany Law School in 1936. He was admitted to state practice that year and to practice in the Federal courts in 1937. That same year, he entered state service as a senior law clerk in the Department of Education; he transferred to the state attorney general's office in 1938 and in 1941 became assistant chief special agent in the Department of Mental Hygiene.

Mr. Wiley had a war leave of absence during which he served with the general counsel to the Federal Security Agency, was operations analyst on the Army Air Force Evaluation Board, and was in the Office of Strategic Services in Washington, D. C. He was appointed to take charge of the newly-created legal division of the Department of Mental Hygiene in 1951. He is a member of the New York and Albany County Bar Associations.

With the late Horatio M. Pollock, Ph.D., he was author of a paper "A Contribution to the History of Psychiatric Expert Testimony" in the *American Journal of Psychiatry* in April 1944. He is married and has two daughters.

MARGARET M. FARRAR. Mrs. Farrar is director of publications and public relations for the New York State Department of Mental Hygiene. She has been in state public relations and public education work for the past 14 years, serving in the Education Department and the Executive Department before coming to the Department of Mental Hygiene in 1948. Before joining the state service, she had taught English in the New York City schools and had served as a professional director of little theaters in New York and Massachusetts.

Mrs. Farrar was born in New York City and is a graduate of Hunter College where she received the Miriam Weinberg Richter award in journalism. She is a member of Sigma Alpha Gamma and a member of Sigma Tau Delta, national honorary writing fraternity.

RICHARD V. FOSTER, M. D.

RICHARD V. FOSTER, M. D.

Richard V. Foster, M. D., director of Gowanda State Homeopathic Hospital since June 1951, was appointed assistant commissioner of the New York State Department of Mental Hygiene on April 15, 1953 by Commissioner Newton Bigelow, M. D. His position is a newly-created one.

Dr. Foster has been in New York State service for 20 years. He was born in 1904 in New York City and was educated there, receiving scholarships both to Columbia College and to the College of Physicians and Surgeons, Columbia University, from which he received his medical degree in 1930. He interned at Grasslands Hospital, Valhalla, N. Y., then was appointed to the medical staff of Rockland (N. Y.) State Hospital in 1932. He went to Pilgrim State Hospital as senior assistant physician six years later and became assistant director after he had been at Pilgrim four years. He served twice as acting medical inspector, then was appointed associate director of Central Islip State Hospital early in 1951, going to Gowanda as director a few months later.

During World War II and afterward until his appointment at Gowanda, he was examining psychiatrist at the Army Recruiting and Induction Center, New York City. He is a diplomate in both psychiatry and neurology of the American Board of Psychiatry and Neurology, is a member of the American Psychiatric Association and other professional organizations, and has been active in both professional and community association work. He served for some years as a member of the Suffolk County Council of the Boy Scouts, and was a member of a special planning commission for Bay Shore (N. Y.) High School.

Dr. Foster was married in 1931 to Ruth Virginia McMullen of Whitestone, N. Y. They have two sons, Richard, 18, and Neal, 16.

NEWS AND COMMENT

LEWIS RETIRES AS INSTITUTE HEAD ON SEPTEMBER 1

Nolan D. C. Lewis, M. D., director for the last 17 years of the New York State Psychiatric Institute, New York City, retires from that position on September 1, 1953 to devote his full time to research and research planning as director of research in neurology and psychiatry of New Jersey Hospitals and Agencies. Born in Coudersport, Pa., in 1889 and a graduate in medicine of the University of Maryland, he served in Maryland general and mental institutions as pathologist, neuropathologist and psychiatrist before going to St. Elizabeths Hospital, Washinton, D. C., where he served from 1919 to 1935 as pathologist, director of clinical laboratories and finally as director of laboratories. He came to New York City in 1936 to be associate director of the Neurological Institute and was named director of the Psychiatric Institute later that same year.

Dr. Lewis will continue his scientific editorial work. He is managing editor of *The Journal of Nervous and Mental Disease, The Psychoanalytic Quarterly* and *The Journal of Child Behavior,* and is editor of the section on psychiatry of the "yearbook series." He is the author of a large number of scientific articles and several books and is a member of numerous professional societies.

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MENTAL HYGIENE DEPARTMENT APPOINTMENTS MADE

William S. Callahan was named assistant director of business administration and Granvill Hills was appointed personnel director of the New York State Department of Mental Hygiene by Commissioner Newton Bigelow, M. D., on May 16, 1953. Mr. Callahan's position, as assistant to Daniel J. Doran, head of the office of business administration, is a new one; Mr. Hills succeeds Mr. Callahan as personnel director.

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MRS. ALMA M. FRANK, PSYCHOLOGIST, DIES AT 55

Mrs. Alma M. Frank, children's psychologist and teacher of the "Alexander method" of psycho-physical education in New York City and California, died at the home of a daughter in New York City on June 2, 1953. She was 55 years old. The former wife of Waldo Frank, the author, from whom she was divorced in 1943, Mrs. Frank had studied infant development with F. Mathias Alexander in London on a Rockefeller grant in 1936. Her later work was based on her studies during this period.

WALTER B. PITKIN, PSYCHOLOGIST AND WRITER, DIES

Walter B. Pitkin, psychologist, educator, writer and editor and one of the most successful men of his time in introducing psychological and philosophical concepts to a general audience, died in Palo Alto, Calif., on January 25, 1953. He was 75 years old.

Professor Pitkin, a graduate of the University of Michigan, had taught psychology, philosophy, fiction and news writing at Columbia University; and elsewhere, at different times, had taught Hebrew, Arabic, French, German, economics and logic. He had done graduate study in Paris, Berlin and Munich. He had been a newspaper writer, editor, chicken farmer, fiction writer, interpreter, printer and psychological adviser to business and industry—in addition to other occupations. His best-selling book of popular philosophical psychology, *Life Begins at Forty*, was followed by a number of others, several written during a personally active period of retirement; his books, mostly of a popular nature, totaled more than 30, with his total of other writings difficult to estimate. Professor Pitkin leaves five sons and his widow—his secretary since 1925 whom he married after his first wife's death in 1943.

WEARNE RETIRES AFTER 40 YEARS OF STATE SERVICE

Raymond G. Wearne, M. D., director of Wassaic (N. Y.) State School since 1937, retired July 1, 1953 after more than 40 years of New York State service. Except for a year's interruption for a general internship at Bellevue Hospital in 1912, Dr. Wearne had been with the state mental hospitals since his graduation from Cornell Medical College in 1910. He had served at Binghamton, Central Islip, Willard, Brooklyn and Manhattan State hospitals, and was first assistant physician at Central Islip at the time of his appointment to Wassaic. Dr. and Mrs. Wearne are living in Poughkeepsie, where they bought a home last year.

CHILD PSYCHIATRY INSTITUTE TO BE IN TORONTO

The International Association for Child Psychiatry has announced a two-day international institute, on August 12 to 14, 1954, will be conducted in Toronto, Canada, in connection with the Fifth International Congress on Mental Health. Attendance will be open to all professional workers dealing with the emotional problems of young children.

OCCUPATIONAL THERAPISTS TO MEET IN HOUSTON

The thirty-sixth annual conference of the American Occupational Therapy Association will be conducted in Houston, Texas, from November 13 to 20, 1953. Lucile L. Lacy, O. T. R., of the Veterans Administration Hospital, Houston, will be conference chairman.

PROFESSOR EDUARD CHRISTIAN LINDEMAN DIES AT 67

Dr. Eduard Christian Lindeman, professor emeritus of social philosophy at the New York School of Social Work, Columbia University, and president of the National Conference of Social Work, died in New York City on April 13, 1953. Dr. Lindeman, a graduate of Michigan State College, held honorary degrees from Springfield, Wagner Memorial Lutheran and Rockford Colleges. He was recognized as a leader of the adult education movement and often regarded as the "elder statesman" of American social workers. He was the author of numerous books, including *The Community, The Meaning of Adult Education, Urban Sociology,* and *Leisure: A National Issue.* He was on the faculty of the New York School of Social Work from 1924 to his retirement in 1950, and during those same years taught or lectured at institutions from coast to coast. He leaves his widow, four daughters and eight grandchildren.

DANISH PSYCHIATRST NAMED TO ROCKLAND PROJECT

Bjorn Vestergaard, M. D., Danish psychiatrist and biochemical research worker, has joined the staff of the Rockland Research Facility at Rockland (N. Y.) State Hospital, as research scientist and assistant to the director, Nathan S. Kline, M. D. Dr. Vestergaard's appointment was announced in May by Commissioner Newton Bigelow, M. D., of the New York State Department of Mental Hygiene. He will be particularly concerned with research in the relationship of hormones to mental disease. He was director of biochemical research at Set. Hans Hospital Ved Roskilde, Denmark, from 1949 until his appointment at Rockland, and he is the author of a number of scientific papers in both Danish and English, dealing with this subject.

SCHOOL PSYCHOLOGIST SYMPOSIUM CONDUCTED

A symposium on the role of the school psychologist in services to the parents of a child with a handicap is being conducted in Cleveland on September 3, 1953 by the Division of Educational Psychology of the Division of School Psychologists of the American Psychological Association, and by the National Society for Crippled Children and Adults. The latter society announces that its publication, *The Crippled Child,* formerly edited for professional workers with the handicapped, is now being edited for a new reader group—the parents of crippled children.

PSYCHOTHERAPY CONFERENCE TO BE HELD IN ZURICH

An international congress for psychotherapy will be conducted in Zurich from July 21 to 24, 1954, it has been announced by the Swiss Medical Association of Psychotherapists. The subject is announced as "Transference in Psychotherapy," and attendance is open both to qualified doctors and qualified and accredited lay practitioners.

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